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This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you are a resident of Ontario and would like to receive this publication regularly, or if you wish additional information about some aspects of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Division, 24 Harbord St., Toronto 5, Ontario (365-4521). Non-residents wishing to receive ADDICTIONS are requested to indicate their professional interest in this field.

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Alcohol Addictions

FALL, 1965

SINCE only one article in this issue deals with prevention of problems instead of their amelioration, it might be well to reinforce the message for alcohol education here.

The most striking thing about Madame Bartonova's Czechoslovakian article (it begins on page 22) is the remarkable similarity reported between the views of a group of well informed Czech physicians and youth workers and those held by many North Americans who are concerned with education to prevent alcohol problems. Cooperative approaches through youth and sports organizations are deemed important, relating information about alcohol to instruction on healthful living generally is commended, and the well known pedagogical principle of the power of the good example is heavily emphasized. (Indeed, some went so far as to suggest that those who cannot serve as good examples in the matter of drinking behavior should be excluded from alcohol education work!)

It is duly reported, also, that "the present day concept of the fight against alcoholism in Czechoslovakia requires neither prohibition measures nor total abstinence efforts and differentiates between suitable and unsuitable ways of drinking alcoholic beverages". The aim is that "normal consumers and abstainers should direct public opinion in the right direction" in order to prevent alcohol problems.

All this from the "Department of Care for the New Generation" in Czechoslovakia's Central Institute of Health Education. ■

— R.R.R.

Drug Dependence Of Alcohol Type

*by John D. Armstrong, M.D., D. Psych.**

THERE is an ancient legend which was reproduced some years ago in the World Health Organization Magazine and which is relevant to this matter of drugs. It tells about three travelers who came to a walled city in the East. When they got there it was after dark, the gates were closed, and they could not get into the city. One of these travelers liked alcohol, another smoked opium, and the third one preferred hashish which we know as marihuana. They talked over their situation and decided what they were going to do. The man who did the drinking said "I'm going to batter the gate down." The man who smoked the opium said, "No, I think I'll just sleep until morning." The third who was using the hashish said "I'll just slip through the keyhole."

Sometimes we are inclined to think that any problems we see in these areas are related to something specific in the drugs, and at other times we are inclined to oversimplify in a different direction and say that the drug is taken to satisfy the need of a particular personality. Some would go as far as to say that the narcotic drugs are used by those aggressive, restless, outgoing people who need to slow down their active behavior in our communities, whereas alcohol is taken by those people who are normally restricted and suppressed in their actions and must find a means of release. This, again, is much too simple a way of presenting the problem. But perhaps one thing we need to think about when we discuss alcohol as compared to the other

* Dr. Armstrong was formerly Medical Director of the Alcoholism & Drug Addiction Research Foundation, Toronto, Consultant Psychiatrist to the University of Toronto Student Health Service and has been Associate in Psychiatry, University of Toronto for a number of years. He is currently with the North York General Hospital Mental Health Clinic. The above article, appearing in the American Journal of Hospital Pharmacy, Vol. 22, March, 1965, represents one of a group of presentations given at a Symposium of the Pharmaceutical Sciences Section of the American Association for the Advancement of Science, Cleveland, Ohio, December 29, 1963.

drugs is that most of the time we forget that we are talking about a drug at all.

We don't regard alcohol as a drug. We think of it in two greatly contrasting ways. One is mostly as an element of convivial celebration with all the components that go with it — the fun, the pleasure the parties, the drunk driving, the accidents. The other, of course, is the deeply significant meaning it has for many of us in our religious observances. In neither instance do we think we are taking a drug.

Initial Safety Dangerous

Ethyl alcohol has been known to us for thousands of years. It is readily available through the fermentation of sugar substances, and almost any substance that grows in the vegetable-fruit world can be turned into alcohol and thereby used. It has not only been universally available but in many respects it has been universally acceptable to us. It is a relatively safe drug and until newer agents came along, it was sometimes a useful drug to the physician.

When I say that it is a safe drug, I mean there is a fair amount of latitude that can be used in dosage. If we take it in modest amounts, we can interfere with our central nervous system through its use and enjoy the effects of that interference and suffer no great harm from it. We can use it over and over again for a long period of time before we encounter any of the indications of increased tolerance, dependence or abstinence syndrome in the person who is using it — the main features of an addiction. One has to work rather hard on the use of alcohol before one can develop a state we call alcoholism. I suppose the paradox is that because it is initially such a safe drug, it becomes universally used and as a result causes much more damage, destruction and death than all the other drugs combined.

It has been estimated that in the United States there are between 4.5 and 6 million alcoholic persons (in Canada, close to a quarter of a million). I think we can number the victims of the other drug problems we have spoken of in the thousands,

not in the millions. Now while this drug in itself is a killer, it is mainly for other reasons that it is a problem. It is true that one may develop a fatal liver disease or the living death of the chronic brain syndrome. More commonly the destruction of alcoholism is based on the disturbed behavior, the death through automobile and many other kinds of accidents, fights, fires, the illnesses such as pneumonia, tuberculosis, diabetes (encouraged and complicated by disturbed living habits and malnutrition), and the destruction that comes in homes or on the job through a person who is functioning much less effectively than he would be if he were not using this drug in rather considerable regular quantities.

Perhaps one of the best examples given is the presentation made by the Royal College of Physicians not long after it was formed in Great Britain some 240 years ago.⁽¹⁾ At that time gin was being imported from Holland in rather massive quantities. The overcrowded, poor, average Londoner at that time had very few pleasures. Gin was cheap, it was available, it was used. So the physicians, the clergy, the lawyers and various other concerned people got together and presented a petition to Parliament. We don't think so poetically now when we make petitions to our government, but in this petition they talked about alcohol as "the solace of the hen-pecked husband, the kind companion of the neglected wife, the infuser of courage into our army, and the support of our pawn brokers." As a result of this presentation, a new tax law was introduced. A great deal of credit was given to this heavy taxation for reducing the consumption of gin and getting Londoners back to good old English ale, a home product, and reducing all their problems. (Don't ever believe, however, that the problem of alcoholism was wiped out in Britain on this account, but it was substantially reduced.)

Alcohol and the Human Organism

When we talk about ethyl alcohol as a drug, I think we should not forget that it has a great variety of actions on the

human organism. For instance, as a doctor, I might want to prescribe it. Sometimes it is useful to the elderly patient because it brings about a certain amount of muscle relaxation and, hence, a certain amount of vascular dilation and it may be useful in the older person with a bit of arteriosclerotic heart disease. But today we are thinking about this drug as a depressant of the central nervous system. Whatever reasons we may give to ourselves about the palatability of a particular beverage, or what it does to our skin vessels, making us feel warm all over, the fact remains that we usually drink alcohol in order to depress and interfere with the central nervous system. It is possible to take alcohol in very small doses. This is one of its advantages over some of the other drugs. The drug is metabolized in the liver effectively and fairly rapidly. So we can take the drug with a reasonable sense of assurance that we can in some way predict what it is going to do to us. Unfortunately, however, it does not take very large amounts of this drug to bring about a certain amount of impairment. Sometimes this impairment is sufficient to interfere with our fine degree of judgment. It is a mild soporific, it relaxes, it will remove pain to some extent, and when it acts on the brain, there are a number of complex things that take place. I don't think we understand all the actions by any means, and I am not going to attempt to relate all of them.

The first functions that are disturbed are those that deal with our complex abilities to think clearly — that seem to have something to do with perception, recognition, memory recall, judgment, action, and so on. Somewhere a little later along the line, there is interference with those actions which we are able to perform more automatically and systematically. Then there is interference with our emotional controls and it is only very late in the process that we get interference with the ability to carry out crude muscular actions and, of course, very, very late, that the drug interferes with our vital centers, the centers that control our breathing and our heart action. Maybe it would be better if the process were reversed because then we would be less interested in the pleasurable sensations from the drug and much

more wary of how we went about using it. I suppose this is what happens, in a way, when we start dealing with methyl alcohol, the drug that some enthusiasts confuse at times with ethyl alcohol and which brings about very severe nervous system damage, blindness and death. I suppose the most significant difference is that this drug is simply not metabolized and excreted quickly and so it very quickly brings about its toxic effects and they remain with the tissues that are affected.

Delayed Recognition

Often the effects of alcohol which come to our attention are the result of the direct intoxicating action of the drug long before we begin to think of a person using it in a way which would cause us to call him dependent or addicted. A person can get drunk on alcohol within a very short time, but he doesn't have to be dependent on it in order to do this; he doesn't have to be an addict. He may never become an addict. On the other hand, a person may use the drug repeatedly over many, many years, never become intoxicated, never show disturbed behavior and yet slowly build up a certain tolerance to it and surely show certain effects if the drug is suddenly withdrawn. Certainly a person may be addicted without ever showing any of the ordinary disturbances we think of as drunkenness. He may at the same time acquire some of the physical distresses that go with alcoholism; he may have brought about some damage to liver, peripheral nerves, even to brain tissue itself. These are areas in which our examination and research leave us feeling somewhat helpless. We are aware of the damage that comes about in the extreme degree when a person has used alcohol and combined it with a poor diet for a good number of years, but are not able to measure effectively the fine points, the critical points, at which this brain damage begins to take place and where we know that a person can no longer learn and function effectively. We see a problem turning up, of course, in his absenteeism from work, his inability to do his job as well as he did before, and his per-

sonality change in the sense that he becomes irritable, forgetful, difficult, and quarrelsome.

Alcoholism — Not A Single Illness

Now, to expand a little on one idea that I believe creates problems when we think of drug habituation or drug addiction. We tend to think of the situation as if it were a single kind of disease problem. This is illustrated when we consider the narcotic addict. We tend to equate the fact that he uses an illegally possessed substance with the disturbed, psychopathic personality who seeks out and carries out an illegal act; we thus tend to see a 1:1 relationship between a certain kind of personality and the particular substance that that person is using. Here on the other hand, however, we have a drug — alcohol — which is more acceptable to all of us, to our whole population. Our attitude toward the person who uses alcohol, even in excess, is quite a bit different from our attitude toward the person who uses narcotic drugs. The tendency with a narcotic user is to think of him always as a criminal because criminals happen to use narcotics. We think of the alcoholic in some different way often because so many of us use the substance. We commonly think about the narcotic addict as a person to be locked up, and very often we are equally horrified if we think of any action that would lock up the alcoholic patient in the course of dealing with an illness.

The late Dr. Jellinek,⁽²⁾ in attempting to look at this problem of alcoholism, decided that we were making a very grave mistake if we tried to think of it as a single illness. He recognized the fact that because this drug is freely available to us, we can use it under all kinds of circumstances to serve many purposes, and many kinds of people will use it. So he divided the problems of alcohol abuse into four groups and he labeled them simply *alpha*, *beta*, *gamma* and *delta*.

The *alpha* problems, to him, were those in which people made use of alcohol for some personal problem-solving purpose. In this sense the alcohol may never be a problem to the person.

An individual may have some form of chronic pain, possibly arthritis, and find that the alcohol is a mild analgesic that gives relief over a period of time. Much more commonly, of course, we see the person who is trying to solve some kind of emotional distress through his use of the drug. It may be anxiety, depression, boredom, anger, insecurity, any of the whole host of symptom situations that the human individual may have as part of his permanent state of being or as a part of his response to a particularly distressing situation. He finds relief in using alcohol. And he can use this substance without ever thinking he is using a drug at all — in fact, without once even thinking that he is sick. So he can carry out a camouflage, a denial, something that allows him to function in the community, by using a drug that is acceptable to the community and never being a sick man in his own eyes or the eyes of others until it is too late. There are also the social pressures, the social reasons, the social distresses to be relieved with alcohol. I suppose the outstanding example of that might be the man who lives on our Skid Row, somewhat like the citizen of London 200 years ago. Life offers very little except a cheap bottle of wine which carries him off into another world very, very quickly. I imagine there are other examples. We can think of people in the little towns that are devoted to lumbering, mining, and other special industries where little attempt has been made to provide any other escape from the boredom of living except the alcohol they can buy.

Dr. Jellinek's *beta* group, by contrast, consists of those people for whom the social custom of the group has said, "We will use alcohol in large quantities. It may be that we use it on the weekend and may be that we use it every day." This practice is not as well known on this continent as it is in some European cultures. People in this group do not have to have psychological problems to drink alcohol as part of the daily pattern, and sometimes the consumption is considerable. We may see the damage of alcohol emerging in individuals who present no psychological difficulties of any significance and yet show the disturbances of liver, peripheral nerves, etc. after years

of day-in and day-out heavy consumption.

The *gamma* alcoholic is probably the most common type of problem drinker that we see as a sick person in our clinics. These are the people for whom the use of alcohol, for whatever purpose, has become the overriding factor. The alcohol has become more important than the original reason for drinking; in fact, it has become more important than anything else. It has reached a point where the individual can no longer predict anything about his drinking. He cannot control it; as a result, any attempt on his part to drink may result in very serious disturbance either in his immediate behavior with intoxication, unacceptable, unpredictable behavior, or in prolonged drinking bouts, benders, and so on with the resulting serious illnesses that are consequent on the prolonged drinking spree.

Finally the *delta* alcoholic, the fourth group, is made up of those persons who show serious disturbance as a result of the social or cultural pattern of use. These people do not get drunk and they do not show intoxication, but they drink heavily day after day, year after year, in such quantities that eventually some damage begins to occur. But more significant than this is the fact that these people cannot get along without alcohol. They are truly habituated and if the drug is suddenly withdrawn from them, they will show signs of abstinence, they will have tremors, they will be wakeful, and they may have hallucinations and convulsions.

Susceptibility to Addiction

The last point I would like to make is to recognize that even though there may be nothing specific at all about personalities that are susceptible to becoming alcoholic, one rather suspects that there is something that makes an individual once susceptible to a drug susceptible in various kinds of comparable situations. So clinicians have learned to be very wary in trying to treat alcoholic patients or to treat patients addicted to any substance, using medications, lest we simply switch the individual from interest in one drug to interest in another.

The interest in tobacco, in coffee, in food, perhaps even in gambling or maybe still worse, in overwork, leads to a transfer of interest of the individual. Sometimes we can change explicit behavior, but we have a great deal of difficulty changing the intrinsic nature of the person that triggered the difficulties for which we are seeing him. ■

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Alcoholism—Present Day Therapy

*by Cameron G. Hill, M.D., F.R.C.P.(C)**

NINE-TENTHS of combined murders and suicides are associated with the excessive use of alcohol. Between 25 and 50% of car accidents leading to fatalities are associated with alcoholic intoxication. A good part of our Welfare bill—from our taxes—is due to alcoholism.

These murder, suicide, car accident and welfare patients are our patients; or their wives or husbands, parents or children are our patients, often our friends and neighbours. And, occasionally, we, ourselves are involved in these incidents.

Somewhere, sometime, before the car accident, before the murder in a drunken rage, before the chronic drinker became a derelict, that man or woman was in a doctor's office or was seen in hospital, or his spouse called asking for help for him. The doctor may or may not have recognized the alcohol problem and tried to treat it, but the chances are that he only treated the gastritis, the head injury, or the insomnia—the symptom

* Dr. Hill is a part-time clinic physician with the Alcoholism Foundation of Alberta, Calgary. His article was originally published in the May, 1964, issue of the Alberta Medical Bulletin.

which was most prominent. The alcohol problem was allowed to get worse, until disastrous results appeared.

We doctors strive to give a leukemia victim a few more months of life, and help a cardiac patient to carry on for a few more years. There should be equal satisfaction in helping a young man who, because of alcohol, has lost his job, his family and desire for living, to return to health, to his wife and children, and to his previous position in business, and watch him carry on as a useful member of society.

Alcoholism is a vast problem but a great many alcoholics can be helped. The problem of alcoholism may be considered under the following headings:

- (1) Why do people drink?
- (2) What constitutes alcoholism?

Therapy in alcoholism may be considered under three headings:

- (1) Acute withdrawal
- (2) Establishment of sobriety
- (3) Making life without alcohol meaningful

(1) Why Do People Drink?

(a) Alcoholism is the oldest and most reliable tranquilizer and sedative known. Despite the activities of many organized religions and pressure groups, 76% of Canadian men and 64% of Canadian women drink. Of those who drink, only 3% are alcoholics. The odds of becoming an alcoholic are less than becoming a traffic accident victim.

(b) Alcohol provides an escape for sudden grief from overwhelming situations—deaths of relatives, loss of job, severe disappointments. People need an escape at times to give their psyches a chance to recover and adjust.

(c) Drinking is a socially accepted custom. Who ever heard of anybody asking somebody home for a Phenobarb or a Meproamate? The majority enjoy and look forward to having a social drink. A drink is an excuse for an enjoyable relaxed social

get-together. Alcohol through its tranquilizing properties achieves this pleasant state. So naturally people drink.

(2) What Constitutes An Alcoholic?

(a) A problem drinker is one whose drinking causes a continuing problem in any phase of his life.

(b) An alcoholic may be considered as somebody who has lost the ability to choose when he is going to drink, where he is going to drink, or how much he is going to drink.

A person may be a heavy drinker, but not allow such drinking to interfere with his life—such a person is not an alcoholic. He is certainly liable to develop a problem, but he is not an alcoholic until he does.

Some people may be alcoholics or problem drinkers yet only drink once or twice a year. They lose control of themselves, and their anti-social behaviour may cause untold misery to themselves and others.

THERAPY

(a) Withdrawal

It may be necessary to hospitalize the patient in order to remove him from his supply of alcohol, or in order to treat the medical complications of his prolonged drinking. This is particularly so if there is a previous history of delirium tremens. Librium in doses of 50 to 100 mgm Q4h I.M. or by mouth, produces good results in controlling anxiety, tremulousness anorexia. On Librium, patients usually become calm and can take clear fluids right from the start. I.V. therapy is often not necessary. Librium has the advantage over Sparine in that it is an anticonvulsant. Sparine and other phenothiazines have epileptogenic properties and may produce so-called "rum fits" during the drying-out period. Chloral Hydrate 1-2 gm. q.h.s. is still the safest hypnotic.

(b) Establishment of Sobriety

An alcoholic to give up his drinking, must be sober for at

least two weeks. This enables him to see things in an unaesthetized state, and free from withdrawal symptoms. He must, in addition, be able to appreciate that continued drinking is going to be less advantageous than sobriety. He has to be able to look at his life soberly, and be self-convinced that by not drinking, things are going to be better for him. The effects of drinking must be kept clearly in front of the alcoholic so that as he looks at sobriety, he can weigh the pros and cons.

Threats and warnings to an alcoholic are of little value. Many alcoholics have an unconscious death wish. A positive approach, with emphasis on a reunited family, good health, and a steady job is much to be preferred.

A large group of alcoholics continue drinking, and while drinking they cannot or will not appreciate the trouble their drinking is producing in the home or at their job. These are the alcoholics whose wives telephone doctors on Saturday night and implore them to do something. These are the problem drinkers whose employers telephone asking what can be done.

In the past, doctors have felt they could do nothing because they assumed:

(1) Alcoholics could only be helped if they wanted to be helped, and

(2) Alcoholics did not want help until they really reached the bottom.

But this attitude of helplessness until the bottom is reached, is wrong. Dr. Gordon Bell puts it forcefully when he writes "in what other disease do we wait until the patient is the sickest before we treat them. We cannot wait until these people hit the bottom and then want help".

By the time alcoholics hit bottom they have lost their health, their homes, and their jobs.

Dr. Ruth Fox, is of the opinion that it may be necessary to create a crisis, in order to make the alcoholic face reality. After making certain that an individual is an alcoholic, action should be taken to make the drinker face reality. His wife may be advised to leave home if drinking does not stop in two weeks,

if he does not seek therapy from a Foundation, a psychiatrist, or go as a voluntary patient to a mental hospital. The wife must be prepared for initial hostility. It may be wise for her to see her lawyer before taking such positive action. Her husband may tell her to get out and good riddance!

There is, however, a greater chance that her husband will, after initial hostility, stop drinking. As he maintains sobriety he will be thankful that his wife "raised the bottom", and made him face the reality of his drinking problem.

The alcoholic's employer, in the same way, should follow similar tactics, and be told that making excuses for the drinker is making recovery less likely. The alcoholic must be made to face reality—the reality that if he does not stop drinking and accept therapy, he will no longer have a job.

An alcoholic may hesitantly seek medical help, and may feel his attempts have been rejected. Alcoholics though pleading for help, have intense feelings of hostility. When they finally want help, they want it immediately. If an alcoholic telephones a doctor and admits he might have a drinking problem this is the time to initiate treatment and rehabilitation. In the first interview the patient must be made aware he has a problem with alcohol, but that he has some positive attributes on which to rebuild his life. A second interview should be made for the near future. The approach to the problem should be emphasis on the necessity for complete, life-long sobriety. An alcoholic is just one drink away from being an alcoholic again.

Antabuse is of considerable help. Antabuse or Temposil will produce a violent reaction with flushing of the face, hypotension, collapse and vomiting, often requiring admission to hospital if even small amounts of alcohol are taken. Patients should take 1 Antabuse each morning for two weeks, then $\frac{1}{2}$ tablet for six months. The patient then has to make one decision each morning—will he or will he not take the pill. The effect of Antabuse lasts about three days. Antabuse may be regarded as a means for each alcoholic to help himself stay sober. It is not a cure in itself. If a patient accepts Antabuse, his chances of remain-

ing sober are better than if he says that he wants to overcome alcohol without taking any pills. Refusal suggests the unconscious desire to drink remains strong.

(c) Therapy — Producing a Meaningful Life

Occasionally, alcoholics who have been sober for several months say that it is not worth it and they are going to drink again. More rarely their wives say that they are almost easier to live with when they are drinking. The answer to these attitudes is to try to make the life of the alcoholic more meaningful. The previous aims or goals were to spend as much time as possible drinking with friends. Sober, the alcoholic has not only lost these goals, he feels he has no longer any real friends.

The most successful abstinent alcoholics are those that find new goals for themselves. Often, these are with A.A., community service, religious movements, establishing new businesses, etc. . . . These alcoholics have learned to control their stressful situations by other means than drinking alcohol or taking pills. They have found satisfactions within a social group.

This reorganization and reorientation of their lives requires the help of doctors, psychiatrists, social workers, ministers, and psychologists. It all takes time. Some alcoholics do not need much reorganizing. Others have such severe personality problems that their goal is sobriety only. Those whose problem has been a lack of direction or purpose in life, often find an altruistic goal can literally make a new person of them.

The facilities of an Alcoholism Foundation can play a great part in this reorganizing and reorientation. A Foundation with its individual counselling services, group counselling, and group therapy sessions can help the alcoholic achieve these goals. In addition, education and better understanding of alcoholism by the wife and family is undertaken by such foundations.

Alcoholics Anonymous has a special place in the overall management of the alcoholic because all members are non-drinking, former drinkers—the most sympathetic and knowledgeable type of friends. As an alcoholic progresses through the 12

steps, he may acquire greater meaning to his life by "12th Step Work" through helping others with their alcoholic problem. The group dynamics of an A.A. meeting emphasize the dependence on other people for relief of tension.

The goals of therapy are well stated by Dr. Ruth Fox, a psychiatrist in New York City.

"The Goals of Therapy"

To attain a state of complete abstinence from alcohol (for the alcoholic can never become a controlled drinker) is but the first step in therapy. Compulsive drinking, though merely a symptom of a deep-seated personality or social maladjustment, has to be brought under control before any attempt at deeper therapy can succeed. The ultimate aim in addition to sobriety should be to render the patient more comfortable with himself and others, more effective in both work and play, more aware of, and sensitive to, his own and others' needs—in short, to help him to attain a greater degree of maturity and social adjustment. To give up the almost completely egocentric orientation of the child for that of the understanding and giving adult is a large order, and is only partially attained in any of us, be we neurotic, alcoholic or "normal".

But this is the goal for every alcoholic if life without alcohol is to be meaningful.

CONCLUSIONS

1. Three out of every 100 people who drink have an alcohol problem. Alcoholism is one of our major public health problems.

2. Medical management of the problem drinker should begin before he hits the bottom and causes irreparable damage. Therapy is directed to making it self-apparent that it is more advantageous for the alcoholic to be sober and accept therapy, than to continue drinking.

3. Therapy does not stop with a month of sobriety, but with

continued sobriety. Counselling, group therapy and A.A. all help to make a life of sobriety meaningful.

4. Helping a problem drinker is often a demanding and time-consuming professional obligation. If a state of sobriety can be maintained in the patient great personal satisfaction is derived from observing the beneficial effects not only to the patient but to his family and to all those with whom he comes in contact. ■

Electricity, Lemons, and "Yoshitomi Solution"

THE association of the idea of alcohol with a painful or disagreeable impression upon some part of the body has taken a myriad of forms over the centuries—often colourful but hardly scientific. With the application of Pavlov's concept of the conditioned reflex, however, the theory was put to systematic test, with the use of nauseant drugs, especially emetine, as the disagreeable factor.

A simple technique has been recently reported by R. J. McGuire and M. Vallance from Glasgow, Scotland.⁽¹⁾ They describe it as being more accurately controlled and more certain than drugs in producing aversion. The apparatus costs little and fits into a box approximately 6 inches square and 2 inches deep; it is, consequently completely portable. It is powered by a 9-volt battery and its construction requires no special skill. The method — electric shock.

The shock, administered through electrodes on a cuff around the patient's forearm, is, at its minimum, imperceptible; at its maximum, unbearable. The strength of the shock is adjusted to be as painful as the individual patient can tolerate. The treatment procedure follows classical conditioning technique. The stimulus to which aversion is to be produced is presented, then a shock is administered. The procedure is repeated throughout the treatment session of 20 to 30 minutes, which

can be held from six times a day to once every two weeks. The patient himself decides how severe the shock should be. Further adjustment of the voltage may be made during the session if necessary.

The technique permits unusual flexibility, since the patient may take the apparatus home and treat himself at will for an unlimited period of time — thus eliminating the need for intervention from the therapist. While the patient can use the apparatus whenever he is tempted to drink, he should also each day deliberately carry out the treatment at a time when the desire to drink is not intense.

At the time of their report, McGuire and Vallance had treated 39 patients, of whom 7 were alcoholics. In 13 the neurotic symptom had vanished — notably among compulsive smokers and sexual perverts — and another 14 had shown mild to good symptomatic improvement. The only basis for selection of patients had been that it seemed appropriate to apply the electric shock technique to the symptom.

Some writers, on theoretical grounds, consider the treatment inappropriate or even dangerous, but others report having applied it in a few cases with satisfactory results.

Report From Soviet Union

B. F. Shilo, director of a section of the Polotsk Psychoneurological Hospital in the Soviet Union,⁽²⁾ describes a treatment for alcoholism notable for its stark simplicity. It takes 29 days to carry out, requires no complicated instruments and no expensive medications — just 225 lemons. It begins with the patient being given the juice of one lemon the first day, of two lemons the second day, and so on until, on day 15, he drinks the juice of 15 lemons. The next day he gets only the juice of 14, and then one less each day until on day 29 he is down to one lemon again.

Shilo does not explain why this treatment should work, but states that he has applied it in five patients who had failed to respond to other forms of therapy, and with satisfactory results.

All of them, he reports, developed a complete indifference to alcohol. One remained abstinent for three years, another for one year.

Cyanamide Solution Yoshitomi

A preliminary report has been received from Dr. Hiroshi Mukasa⁽³⁾ about a treatment for alcoholism by means of "cyanamide solution Yoshitomi". The report describes both a "Temperance treatment" — that is, administration of the solution in an effort to reduce alcohol tolerance so that the drinker is unable to take in more than a limited quantity of his favourite beverage without unpleasant effects; and "abstinence treatment". The abstinence treatment is very similar to that achieved by the use of drugs already common in North America and elsewhere (Antabuse and Temposil); and according to some clinicians, even these more common drugs, which reportedly produce a stronger reaction in the presence of small quantities of alcohol, can in some dosages and with some patients permit a limited social use of alcohol as described in the Japanese literature on "Temperance treatment".

The Japanese report, however, quite properly offers words of caution about the use of the cyanamide solution Yoshitomi. It states that test doses of alcohol should be carried out under the supervision or direction of a physician; and it states also that the abstinence treatment should not be carried out unless the patient is informed about the drug and its effects and properties. It also warns against possible side effects, particularly in patients who may be afflicted by heart, kidney, liver, or lung ailments. However, clinical trials reported in the Japanese literature refer to beverages such as Sake and Japanese beer and do not refer to beverages commonly drunk in this country. ■

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Alcoholism Research Foundation of U.S.

STEPS taken recently in the Court of Common Pleas of Montgomery County, Pennsylvania, began a full-scale attack to coordinate all significant scientific approaches on the problem of alcoholism.

The charter sets up a non-profit corporation, The Alcoholism Research Foundation of the United States, with headquarters at 120 East Lancaster Avenue, Ardmore, Pennsylvania. It authorizes the Foundation "to engage in, assist, create and maintain or contribute to the support of" both basic research and clinical patient care and research "in regards to alcoholism and related problems" on the broadest basis.

Seeks Moderate Solution

The Foundation establishes one integrated organization dedicated to finding the cause and cure for the alcoholic, with the hope that ultimately new knowledge will lead to developing a mechanism by which the problem drinker can control his drinking yet, if he wishes, continue social drinking rather than having to become a teetotaler. In short, the Foundation's goal is to develop a moderate solution in place of the choice of extremes of devastating illness or complete abstinence.

Mrs. Marty Mann, founder and executive director of the National Council on Alcoholism, is slated to become a member

of the board of directors of the new Foundation which will concentrate at the research level while the National Council continues its progress with its affiliated councils across the country, in helping to educate the public.

A special approach which the Foundation hopes may provide an answer to the problem is under way at Gwynedd-Mercy College, Gwynedd Valley, Pennsylvania. Here, the biochemical and metabolic aspects, the physiologic approach are being followed with laboratory animals to determine their addiction liability and changes in their metabolic profile induced by alcoholism. The program is focused on three areas: the absorption problem, pharmacology, and biochemistry to determine if alcoholics may lack a specific enzyme needed properly to metabolize alcohol, or if a key enzyme is inhibited. New knowledge is available in biophysics and biochemistry to help this group of researchers, under the direction of Dr. Gustav J. Martin, Visiting Research Professor in Biology at Gwynedd-Mercy College, investigate the steps in the metabolic chain of conversion of alcohol—in short, to look for unrecognized factors which produce a disease, not just inebriation, from chronic administration of alcohol. However, investigations conducted or supported by the Foundation will not be limited to any specific field.

Disciplines Encouraged to Cooperate

One goal of the Foundation is to provide a "switchboard" type of service through which isolated workers in the field can be brought into contact through meetings, publications and library facilities. It also hopes to foster a more fruitful interchange among scientists studying the problem from the psychiatric, sociological, genetic and metabolic standpoints, at both the basic research and clinical levels, and to aid them in working together. It particularly hopes to encourage scientific synthesis and correlation of ideas and disciplines while laboratory work is maintained, to determine a conclusive picture of what makes up the alcoholic, from which clues might be determined to provide him with a mechanism with which to control his

difficulties yet have access to the same satisfaction from alcohol available to other people.

As a tax-exempt corporation, the Foundation will seek funds from individuals, private and public organizations including corporations and philanthropic foundations, which could be used to support or assist charitable, educational and scientific activities in the field of alcoholism.

The initial board of directors is scheduled to include, in addition to Mrs. Mann, Malcolm Meyer, President of Certain-Teed Products Corp., James H. Stevens of Stradley, Ronon, Stevens & Young, attorneys, Archibald G. Thomson, Jr., Dr. Martin, who is Director of Research of William H. Rorer, Inc., Dr. Martin Kissen, Director of the C. Dudley Saul Clinic of St. Luke's and Children's Hospital in Philadelphia, Robert J. Sims of Mutual Life Insurance Company of New York, Dr. Louis Gershenfeld of the Philadelphia College of Pharmacy and Science, and Martin B. Christy, Jr., Public Relations Manager of the Bell Telephone Company of Pennsylvania. ■

Czechs "Care for New Generation"

*by Milena Bartonova**

THE aim of education is to develop abilities, interests, a general conception of the world and qualities of good character in man. Man meets complicated and varying conditions during his life. Conscious learning, based on understanding, conscious control of the learning process and its results and understanding of the significance of knowledge enable him to adapt himself to these conditions. The fulfillment of these conditions is also necessary in anti-alcoholic education which forms an inseparable part of the total education.

* Madame Bartonova is with the Central Institute of Health Education (Department of Care for the New Generation), Prague, Czechoslovakia.

Teachers Aware of Problem

Conscientious teachers have always paid attention to this question. The writings of J. A. Comenius have drawn attention to the fact that alcohol endangers the health of the nation especially the health of children. He cites the example of Sparta, where young people were not given wine until they reached the age of 20—when they were considered “fully grown up”. In his *Informatorium* for kindergarten he impressively warns not to give spirits to small children. In his work *Gentis Felicitas* he showed that “the conditions and signs of national happiness are good behaviour of youth, profoundness of education, sufficient number of good schools, good books and good instructions and habits in the education of youth”. It is not necessary to emphasize that drinking alcoholic beverages cannot be considered a good habit for youth. In this connection, it is suitable to mention what Comenius asked from the teachers: “Let teachers be a living example of the virtue to which they should lead others.” This requirement is still valid and is one of the most important factors of correct upbringing.

Educating the Teachers

How are the teachers of today informed about the anti-alcoholic education of children? In the textbook for students of the Pedagogical Faculty there is a special chapter concerning anti-alcoholic education. It is founded on the results of research carried out by the Central Institute of Health Education in recent years. The requirements for the instruction and education of youth are stipulated according to these practical results. (The legal foundation of the anti-alcoholic education of youth is the law No. 120/62 Sb., especially its regulations regarding children and youth.) A very important part of the education is found in the anti-alcoholic chapters in the curriculum for preparatory school (6 to 15 years) and eventually in the plans of schools of higher levels.

Curriculum Incorporates Alcohol Education

The children learn about these questions for the first time

in third grade history (of Czechoslovakia)—in the chapter dealing with healthy and noxious beverages. In seventh grade civics, the harmfulness of alcoholic beverages is treated directly. In eighth grade biology the prohibition of alcoholic beverages to youth is clarified and motivated by mentioning the harmful consequences of alcohol for health and society. Some information is also provided in the chemistry textbook for the eighth grade in which it is stated: "Alcoholic beverages contain ethyl alcohol which has a harmful effect on the human organism."

Alcohol is dealt with in greater detail and its harmful effect on the human organism is underlined in the chemistry textbook for first year high school. And in second year chemistry, there is a description of the technological process of the production of alcohol. Its harmfulness, however, is not mentioned in the same manner as in the chemistry textbooks for technical schools. In third year biology (students 15 to 18 years), the question is dealt with within the problem of principles of correct nutrition and healthful living habits.

A short and more characteristic evaluation of alcohol and its properties is contained in the textbook of organic chemistry for industrial schools. In this textbook the danger of addiction and its consequences for the human organism and the effect of alcohol in the growth period is described. The influence of alcohol is dealt with in psychology and industrial hygiene in fourth year technical school.

A special analysis of the textbooks on literature from the viewpoint of anti-alcoholic education was carried out by a teacher who is a member of an anti-alcoholic committee co-operating with the Department of Treatment of Alcoholism at the Psychiatric Clinic in Prague. Drinking is criticized in prose and poetry; however, some situations are described which could lead the children to imitation. The analysis has been given over to education specialists who are choosing the reading selections.

Questionnaire on Alcohol Education

What is the relation of people engaged in anti-alcoholic work

to the problem of anti-alcoholic education of youth? We thought it important to obtain factual information on the viewpoints and experiences of these workers. We used the questionnaire form because these persons were from different parts of Bohemia and Moravia. We sent out 160 questionnaires and 99 were returned (62%). Seventy-seven were completed by physicians—a fourth of them working in health education. Most of the others were youth medical officers and physicians working in anti-alcoholic therapeutic institutions. The remaining respondents (about one fifth) were members of the procuratorships and anti-alcoholic committees, teachers, etc. The results of this enquiry have been analyzed with all the reserve which must be borne in mind for this kind of investigation. Our analysis was based on the present day concept of the fight against alcoholism in Czechoslovakia, which requires neither prohibition measures nor general abstinent efforts, but differentiates between suitable and unsuitable ways of drinking alcoholic beverages. In co-operation with everyone dealing with youth, we systematically influence the public with the aim that normal consumers and abstainers should direct public opinion in the right direction in order to prevent drinkers and alcoholics—a negligible minority—from exerting their influence.

Results of Investigations

—The experiences of those who answered our questionnaires confirmed the attitude of parents known to us from our previous research. The children generally do not give a part of their earnings to their parents, and often use it for the uncontrolled purchase of alcoholic beverages.

—Almost all (92%) were of the opinion that a close co-operation with youth and sports organizations, and the Czechoslovak Red Cross was most important. (This confirms our findings from a previous investigation.)

—In spite of the fact that the participants knew the importance of special information about the alcoholism program, the large majority (80%) recommended uniting the anti-alcoholic

problem with the information on healthful living habits, with instructions for engaged couples, drivers, etc. They recommended specialized anti-alcoholic instruction only if those for whom the educational action is prepared underwent a positive or negative experience. Their point of view was the same as that received from former youth and adult investigations. The questioned persons answered generally about the harmful effect of alcohol to health; however, their attitude toward consumers of alcohol, and sometimes even toward habitual drinkers was very liberal.

—According to the answers in the questionnaire, the majority (85%) believes in the effectiveness of a well-elaborated film, and then in the classical form of lectures and discussions. In spite of the fact that many times we have heard critical remarks of this form, we agree with this opinion. We also verified their effect on youth in previous investigations.

—The well known pedagogical principle that the best means of education is a good example is mentioned by nearly 100% of the people questioned. Sometimes the commentary is added that those who cannot serve as an example should be excluded from anti-alcoholic educational work.

—We also obtained valuable information on publications for lectures and films most commonly used. According to these results, we arranged the publicity for several further suitable means of education.

—Only about one fifth (17%) of the people questioned were in favour of enlargement of this problem in the school curricula. They probably considered the problem sufficiently dealt with. However, the influence of parents and educators—the methods and forms—become more important.

Conclusions

We are of the opinion that this enquiry has proved a contribution, because the previous attitudes and experiences of people working in anti-alcoholic institutions were published, rather as discussions of individuals or small groups of people

working in this field. The enquiry has been one of a series of research activities of the Central Institute of Health Education in this field.

The basic anti-alcoholic education, which is regulated by legislative anti-alcoholic measurements and the education in schools, is being completed by educational measurements led by the Central Anti-Alcoholic Council; on the regional level by the Regional Anti-Alcoholic Committee; and in the districts by the District Anti-Alcoholic Committee. These committees include the representatives of all institutions. Their members cooperate also on programs of mass media, eventually on the editing of publications—such as books, posters, leaflets—or on the programs of Civic Courses for Youth in the lectures concerning anti-alcoholic education, on the preparations of discussions among youth, etc.

Anti-alcoholic education, which is a significant part of the whole education, is based on the concept of the profile of youth within the principles of our society. The main aim of such education is to bring up a new generation mentally, morally, and physically fit. ■

Good Medical Practice in the Care of the Narcotic Addict*

**A Report Prepared by a Special Committee Appointed
by the Executive Committee of The Canadian
Medical Association**

Dr. J. K. W. Ferguson, Toronto, (Chairman)

Dr. G. H. Ettinger, Toronto

Dr. Guy E. Joron, Montreal

Dr. John J. Lederman, Vancouver

Dr. David J. MacKenzie, Toronto

NARCOTIC regulations in Canada, Britain and the U.S.A.
are essentially similar in permitting a doctor to administer

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a narcotic to an addict or to prescribe such for him, if the addict is a patient under that doctor's care. Under Canadian law the onus is on the doctor to present credible evidence that the narcotic is "required for the condition for which the patient is receiving treatment".

At a Conference on Narcotic Addiction in February 1963, which was sponsored by the Addiction Research Foundation of Ontario, the question was raised as to what was meant by the expression "required for the condition for which the patient is receiving treatment". Could it include the prescribing of maintenance doses of narcotics for long periods outside an institution, but as a part of a program aimed at eventual withdrawal of the narcotic? The legal adviser to the Department of National Health and Welfare replied to the effect that if such a procedure is recognized to be good medical practice it could hardly be regarded as illegal. He felt, however, that it was the responsibility of medical authorities to define "good medical practice" in this context. Since this program is one of national concern, the Executive Committee of The Canadian Medical Association established a special committee to formulate advice to practising doctors in this regard.

The special committee felt that it should try to answer the question raised in the previous paragraph, and in addition to formulate advice for doctors who seldom see narcotic addicts but who may on occasion be confronted with varied and difficult problems presented by narcotic addicts. There is good reason to do this at the present time, because in recent years there has been considerable discussion about narcotic addiction in both lay and medical publications. As a result, some doctors have taken more interest in trying to treat narcotic addicts and some addicts have taken advantage of a more relaxed attitude on the part of doctors to obtain supplies of narcotics from several doctors, which is illegal.

It is necessary to emphasize that no advice in this report should be construed as limiting or directing in any way the activities of organizations or specialists engaged in research on

the treatment of narcotic addicts. Such organizations should be encouraged to develop their own policies and their own methods and to subject them to critical evaluation.

Addicts as Patients

It is customary to classify narcotic addicts into three categories, "professional," "medical," and "street" (or "criminal") addicts.⁽¹⁾ (1) Professional addicts are engaged in some profession or vocation which permits access to narcotics, e.g. doctors, nurses, pharmacists, and veterinarians, and therefore have more opportunity than other persons to become addicted, and to support an addiction secretly — in some cases for many years. (2) Medical addicts are persons for whom narcotics have been prescribed for a long time because of painful ailments, and who thus have acquired an addiction involuntarily. (3) Street addicts are those who associate habitually with criminals and support their addiction by illicit activities. They are by far the largest group of the narcotic addict population and number perhaps 3000 in Canada.⁽¹⁾

It seems fair to say that most street addicts do not regard themselves as sick persons. Addiction is a part of the way of life which they have chosen or fallen into as a result of their associations. Treatment of such persons by methods now known to any of the health sciences has been disappointing in a majority of cases. To expect that all of these persons would accept the role of "patient" would be unrealistic. Most of them have little sympathy with the aims of treatment, if that means life without drugs, sooner or later. Many of them display great skill and ingenuity in manipulating doctors to achieve their immediate objectives.

In commenting on the foregoing classification it is necessary to point out that individual humans are seldom adequately described by simple categories. Many persons do not fit neatly into any of the three categories; some may fit all three. Some addicts do wish to free themselves from the habit, and do benefit from treatment and social assistance.

Two institutions in Canada are now offering "treatment" to street addicts who are not under legal commitment or restraint. One in Vancouver has been operating since 1956 and is known as the Narcotic Addiction Foundation.⁽²⁾ The other opened in Toronto in 1963 and is operated by the Alcoholism and Drug Addiction Research Foundation of Ontario.

It is reasonable to hope that these two institutions will in time provide information which may modify present views as to good medical practice. They are organizations designed to provide service as best they can in the light of present knowledge, to introduce new methods of treatment, and to conduct research which must necessarily be sustained for many years.

Treatment in Custody

In addition to these enterprises there have been developments in our penal institutions. The Department of Reform Institutions of Ontario established a clinic in 1956 for the treatment of addicts towards the end of their term of imprisonment who so elect and are judged to be suitable for treatment. A progress report of this experiment has been published.⁽³⁾ The results are moderately encouraging. Another treatment clinic was established in 1963, by the Ontario Department of Reform Institutions, for female narcotic addicts.

A new Federal Act, the Narcotic Control Act, was passed in 1961 to replace the old Opium and Narcotic Drug Act. Part II of this Act recognizes that the addict is a sick person and provides for "preventive detention and custody for treatment". Part II has not yet been proclaimed, pending the completion of a suitable Federal institution for custodial treatment. The new act has been described as "one of the more advanced statutes of its kind today".⁽⁴⁾ It provides for continuing supervision under the Parole Act after release of the addict, during which time "treatment" can be continued. Workers in the health sciences and social sciences have yet to develop conspicuously effective methods of treatment, which means, in essence, persuading and assisting street addicts to become relatively useful

citizens; but they are trying. Bystanders should not, however, expect spectacular results in a hurry.

The facilities of the mental hospitals of most provinces in Canada are used to some extent for the treatment of addicts of narcotics and other drugs. Patients may be admitted by certification or, to some mental hospitals, as voluntary patients. In a few mental hospitals experimental programs for the treatment of addicts have been undertaken.

Purposes of Treatment

It is sometimes claimed that many addicts can function satisfactorily as wage earners, in business or in a profession, if they have access to a steady supply of narcotics at a reasonable cost.

Many addicts like to believe this and some have persuaded certain journalists and doctors that cheap narcotics would be the best solution to their problem. It is beyond the scope of our report to explore this hypothesis, intriguing as it is. The bulk of evidence indicates that narcotic addiction is, for most victims, an incapacitating affliction which tends to progress if it is not interrupted. Many narcotic addicts take readily to other drugs when narcotics are hard to get. Mixed addictions to barbiturates, amphetamines and alcohol are becoming increasingly common. They may be more destructive than addiction to narcotics only. Without denying that a few patients might ideally be managed by prescription of small amounts of narcotics for indefinite periods, we are of the opinion that such an objective is rarely desirable or practical. The aim and purpose of medical treatment must be, in nearly every case, to relieve the patients from dependence on any drug and not simply to transfer his dependence to medical prescriptions or to any sedative or tranquilizer which may be obtained more easily than narcotics.

What is Treatment?

It is generally recognized that withdrawal of narcotics and

restoration of physical health are not hard to accomplish if a patient is confined in a suitable institution. During some weeks or months after withdrawal physical craving may recur periodically, with lessened intensity each time, until after several months or a year, physical craving (but not the psychological urge) ceases to be a problem.

Withdrawal of narcotics from an addict who is free to come and go as he pleases and carry on his usual occupation, whatever that may be, is a more uncertain undertaking, with respect to both short-term and long-term prospects of success. It is being tried by at least two clinics in Canada and by an unknown number of private physicians. A doctor who agrees to supervise such a course accepts a difficult assignment. He is free to do so if, in the light of all known circumstances, he considers it wise to try. He has no obligation to do so if, in his considered opinion, such a course is unwise for any reason. Successful withdrawal is only a minor part of treatment.

From the very start of treatment a systematic and time-consuming effort must be made to analyze the emotional and social problems which make addicts so likely to relapse after withdrawal. Professional addicts are likely to have different problems from street addicts, but they may be no less difficult to manage. Pride may prevent them from accepting advice or help from anyone. All too often they choose suicide. The methods of influencing psychosocial derangements are often loosely described as psychotherapy. There are many philosophies and systems of psychotherapy. None of them has been so highly successful with addicts as to deserve special endorsement. The general physician who elects to treat an addict over a long period—and it must be for a long period — should certainly enlist the help, in consultation, of a psychiatrist, if only to assist with diagnosis and evaluation.

The most important element in the treatment of the core of the disorder called addiction may be described as the systematic application of personal influences which are supportive, acceptable socially, and acceptable to the patient. It is not

surprising, therefore, to find that lay organizations and religious organizations can often be more effective than medical intervention in altering the ways of the addict. One such organization is Synanon, which is composed of former addicts who are dedicated to the reclamation of other addicts.⁽⁵⁾⁽⁶⁾ Incidentally, in Synanon the use of narcotics to alleviate withdrawal is not permitted.

The doctor who undertakes to treat an addict assumes a professional responsibility to do more than supervise the withdrawal of narcotic. He must enlist all available medical resources to diagnose and evaluate the condition of each patient. After thorough evaluation of the various disabilities and assets of his patient, he is obligated to enlist all relevant specialties of the health sciences to help in treatment, and such social resources as the community may offer. It must be infrequent that the treatment of the addict can be justified as a solo effort.

The Private Practitioner

The following advice is offered for the guidance of individual physicians who are not highly experienced in dealing with narcotic addicts, but who may encounter them occasionally in their practice.

A narcotic addict may present himself to a physician under one or more of the following circumstances:

(a) Addiction is admitted and alleviation of withdrawal symptoms or impending withdrawal symptoms is requested.

(b) Symptoms of painful illness are simulated.

(c) Physical illness is evident or suspected by the doctor, with or without withdrawal symptoms at the time.

(d) An addict may request help to carry through a program of withdrawal, starting forthwith.

(e) Long-term supportive treatment is requested with some prospect of eventual resumption of a normal life without drugs.

(f) Indefinite maintenance of narcotic use is contemplated on account of intractable disease without prospect of recovery.

1. Under most circumstances a doctor is justified in sending

away a strange addict, or referring him to a hospital or clinic without giving him any narcotic, unless some ailment requiring immediate treatment is suspected. It is almost impossible for the doctor to be sure that the addict is not systematically soliciting many doctors for additional supplies. If he decides to give some narcotic, methadone hydrochloride (Dolophine, Physeptone), 5 or 10 mg. by mouth, will nearly always be adequate. No injection is necessary, nor should the addict be given additional supplies to take away.

2. A great worry to the doctor is the addict who presents himself as suffering from severe pain in the chest, abdomen, loin and groin. The addict usually has a story well designed to make a diagnosis impossible in the office. Arrangements should be made to have necessary radiographs, electrocardiograms or chemical tests performed. A dose of methadone may be given. It need not cause surprise if the addict fails to keep the appointment for the diagnostic service.

3. When the doctor suspects that the patient has a serious illness complicated by addiction, he may have a difficult situation with which to deal. The patient may not co-operate, fearing hospitalization or other restraints. The doctor may be wheedled by various devices into maintaining the patient on narcotics much longer than is wise. At this point consultation with a medical colleague or referral to a clinic is recommended. At this point too, the doctor should secure the consent of the patient to identify him to the Department of National Health and Welfare as an addict under treatment. He should be told that the Department has the authority to demand this information and will probably do so in due course.

4. The management of a narcotic addict through a course of withdrawal, outside an institution where the administration of drugs can be controlled, is generally regarded as a fruitless endeavour on the part of an individual doctor, and should not as a rule be attempted by doctors working alone. An exceptional circumstance might exist if the doctor has special knowledge of a patient which may make the prospects of success somewhat

credible. If the treatment of the addiction is undertaken, it should be on the condition that the patient consents to be identified as an addict to the Department of National Health and Welfare. This is a protection for both the doctor and the patient.

5. In recent years the idea of keeping an addict on maintenance doses of narcotic until he learns how to live in some socially acceptable manner has been introduced (or revived) by Lady Frankau.⁽⁷⁾ She believes that narcotic addicts (some at least) should be given maintenance doses of narcotic provided while under psychotherapy, part of which includes steady socially acceptable employment. It is her thesis that if the addict can learn to live in a relatively normal fashion on maintenance dosage, his chances of continuing to do so after withdrawal are greatly increased.

Clinics which are engaged in the treatment of addicts will doubtless try Dr. Frankau's methods with various modifications.

For a private physician to undertake such a task with a number of addicts would be an ordeal, to say the least. No physician should be put in the position of being coerced to attempt such a course of therapy against his wishes and considered opinion. Consent from the patient to report him to the Department of National Health and Welfare should be a prerequisite for attempting such treatment, and consultation with one or more respected medical colleagues should be a part of the plan of treatment.

6. The chronic invalid who has become addicted to narcotics may present many varied problems and seldom escapes attention from the officials who are required to enforce the Narcotic Control Act. The doctor should report such patients before his actions and motives can be questioned and should see that his management has the support of a competent consultant.

Many doctors in Canada have taken, and are taking, great pains to treat addicts, particularly those whose background is known to them and who seem to possess sufficient motivation and capacity to respond to therapy. A major problem for the doctor is to know when a patient is deceiving him and breaking

the law by getting drugs from other doctors or from illegal sources.

The problem is particularly acute in the management of addicts who are well versed in the ways of the underworld. It is hardly less difficult when the patient is a professional colleague whose knowledge permits him to experiment with a variety of drugs which may range from alcohol to amphetamines.

Summary

If a physician elects to treat a narcotic addict, the principles of good medical practice which should be applied can be summarized as follows:

A good history must be secured and checked by independent evidence whenever possible.

A thorough physical examination is essential. A careful inspection of the patient's whole body for marks of injections will help to verify the patient's story as to the frequency and mode of administration of drugs. If required, laboratory tests should be performed to establish the existence or extent of physical ailments which may be suggested by history and physical examination.

Prescriptions for narcotics should be written to be filled by one pharmacy or dispensary only, on specified dates and at specified times if necessary. There seems to be little need at this time to prescribe any narcotic other than methadone by mouth for alleviation of symptoms during gradual withdrawal, or for prolonged maintenance. An adequate case history should be maintained for each patient, and it should include an accurate record of all prescriptions issued for that patient.

If the doctor has any doubts about the sincerity of his patient or suspects that he may approach other doctors for help, he should secure permission in writing from the patient to identify him to the Narcotic Control authorities, before any treatment involving prolonged, repeated use of narcotics is instituted. This is a protection to the patient and to the doctor, and evidence of sincerity. The patient should be warned that

he will be in "illegal possession" if he obtains drugs from more than one doctor without full disclosure of the facts.

For the individual practitioner who proposes to treat addicts, consultation with a respected colleague is essential. It can be accomplished in a number of ways, for example by referral for psychological assessment or psychotherapy, or referral to an internist for physical assessment or therapy. If there is a suitable clinic or social agency in the neighbourhood, its resources should be enlisted. A cardinal principle of treating addiction is to focus on the patient as many helpful personal contacts and supportive influences as possible.

It is always good medical practice for a doctor to refrain from undertaking therapy in fields in which he has little experience and no special training, if more competent professional help is available.

Our answer to the question which prompted this enquiry is that it may, in certain circumstances, be good medical practice to prescribe maintenance doses of narcotics for long periods to an addict at liberty, if other components of good medical care are also provided. If they are not, the doctor may be guilty of trafficking. Our advice to general practitioners is that they should, if possible, avoid prescribing narcotics for long periods for addicts under their care. ■

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Drug Addicts — Are We Creating Them?

*by Judge J. de N. Kennedy**

WHILE it is obviously impossible to have accurate statistics showing the number of narcotic addicts in a country at any one time, it is generally accepted that the following figures represent an approximate and conservative estimate of the number of narcotic addicts now living in Canada and Britain:

In Canada	3,300
In Britain	250

Assuming that the above statistics are approximately correct, why is it that with a population of less than one half of Britain we appear to have about 12 times the number of narcotic addicts? In search of an answer let us look at the history of narcotics, and examine the system of dealing with narcotic addiction in Canada and in Britain.

History

Many people imagine narcotic addiction to be a disease of modern society and forget that for thousands of years miscellaneous substances or liquids have been eaten, or drunk, to provide a "lift" or to dull a pain. In all societies at all times there have been and probably always will be people who become what we call "drug addicts".

However, the belief that the consumption of drugs is wrong or harmful only appears to have arisen in relatively recent times. In 1729 in China a royal decree was proclaimed prohibiting the sale of smoking opium. In some parts of Germany, Prussia and Russia the smoking of tobacco was punishable by death, and at one time Turkey had a law providing for the death penalty in forms agreeable to God for the violation of a tobacco decree. There is a cynical theory that the chief reason for the early

* Judge Kennedy is a retired County Court Judge, Peterborough, Ontario. His article originally appeared in the November, 1964 issue of Chitty's Law Journal.

prohibition of tobacco, liquor and drugs in the western world arose from a belief of the early Christian Church that any form of indulgence which is pleasurable must, by its very nature, be a sin.

Toward the end of the 19th century heroin, a derivative of opium was discovered. At that time heroin was thought to be a miracle pain remover with all the qualities desired and none of the dangers. As time passed, however, it was found that those who were given heroin rapidly became heroin addicts and nowadays its use in medical practice has virtually ceased.

For reasons later mentioned, heroin now has become the most common drug of the addicts of North America. The heroin addict, if deprived of the drug, will, to satisfy his desperate hunger for it, lie and steal, but contrary to public belief he will rarely commit a crime of violence and while he is under the influence of the drug he is in a state of euphoria.

The two drugs which are less commonly used are cocaine and marihuana. Addiction to cocaine is probably one of the most injurious of all drug habits. Under the influence of cocaine the moral and mental qualities of the individual become changed. The user suffers from hallucinations and personality changes. He becomes unpredictable in his behaviour and is capable of crimes of violence. Marihuana is not used medically in Canada, but has for a long time constituted a dangerous drug in a number of countries. In some Asiatic countries it is known as Hashish. It is made from a weed which has been found growing wild in some parts of Canada. It is smoked in the form of a cigaret usually known as a "reefer". It is not addictive in the sense of the opiates but it is a dangerous drug which produces hallucinations and other symptoms which are similar to those produced by cocaine. It is frequently found to be a stepping stone toward addiction to heroin. Young people by smoking marihuana often graduate to heroin.

General Remarks

Drug addiction has been defined as a state of periodic or

chronic intoxication produced by the repeated consumption of a drug. Its characteristics include:

- (a) an over-powering desire or compulsion to continue taking the drug, and to obtain it by any means;
- (b) a tendency to increase the dose, though some patients may remain indefinitely on a stationary dose;
- (c) a psychological and physical dependence on the effects of the drug.

Drug addicts can be divided generally into three groups: first, professional persons, namely, doctors and nurses, who have become addicted to narcotics to which they have ready access; persons who have been given narcotics for therapeutic reasons when ill with resulting addiction; and thirdly, persons who have become addicted for miscellaneous reasons and through association with other addicts.

There is an inclination to overlook the fact that many addicts are capable of being productive workers and law-abiding citizens while using narcotics, while emphasis is placed on the fact that some addicts, when denied the drug of their addiction, are afflicted with a desperate hunger for the drug and, like a person starving for food, will lie and steal to obtain it. Since doctors in Canada are mostly unwilling to accept drug addicts as patients, most drug addicts become wholly dependent on the drugs imported by gangsters which are sold to them at exorbitant prices. They live from hand to mouth, anxiously looking forward each day to securing the narcotics which they believe they must have to survive.

Heroin, the most popular drug of the addict, comes from Europe where it can usually be bought at prices varying from \$150 to \$300 an ounce. The original purchaser does not usually take delivery himself but acts as a jobber and resells the quantity he has purchased to a gangster in Canada at two or three times the price he paid. The gangster who made the purchase will in turn resell the heroin to local traffickers at two or three times the price he paid. At this point, the usual practice is to adulterate the heroin and thus increase the bulk.

The street pedlar, or "pusher", who buys in small quantities usually once more adulterates the heroin to increase its bulk before he sells it, and to increase the number of his prospective purchasers, a pedlar will often encourage others to try a "shot" and the latter may become addicted with a few shots in a short period of time. By the time heroin reaches the addict it will usually have been cut to a small percentage of its original strength. At some point along the line of distribution the heroin is usually put into small gelatin capsules which provide the unit for sale. The price per capsule will be some five or six dollars depending upon the supply. The foregoing is a rough outline of how heroin and other drugs of addiction are imported into and sold in Canada.

The average addict will require narcotics from three to five times per day depending upon the extent of his addiction, and to pay for such narcotics he must have some twenty or thirty dollars in his pocket. It is rarely that an addict can earn enough money to pay for his supply of narcotics and usually he must obtain the money he needs by unlawful means. The male addict usually turns to shop-lifting and petty theft; the female addict usually turns to shop-lifting, petty theft and prostitution. Since stolen goods can only be sold at a fraction of their retail price a drug addict who has to pay even twenty dollars a day for narcotics must steal, every day, goods having a value probably exceeding forty dollars.

Many people have urged that efforts to cure drug addicts should be concentrated on young addicts in the belief that they will be easier to rehabilitate. Experience, however, has shown that the young addict is the most difficult to cure and that the most hopeful period is after middle age.

Drug addiction is little known in rural communities, apparently because a drug addict will usually go where other addicts congregate to ensure a ready source of supply and where he can obtain the companionship of other addicts.

The increasing prevalence of drug addiction, particularly through the use of opium and its derivatives, morphine and

heroin, and through the use of some of the synthetic opiates, is becoming year by year an ever-increasing problem.

Treatment of Addicts in Canada

In 1961 the Federal Government repealed the old Act known as the Opium and Narcotic Drug Act and in its place enacted the Act known as the Narcotic Control Act, 1960-61 (Can.), c. 35, which is now in force. The Narcotic Control Act provides, *inter alia*, in ss. 3, 4 and 12:

3. (1) Except as authorized by this Act or the regulations, no person shall have a narcotic in his possession.

(2) Every person who violates subsection (1) is guilty of an indictable offence and is liable to imprisonment for seven years.

4. (1) No person shall traffic in a narcotic or any substance represented or held out by him to be a narcotic.

(2) No person shall have in his possession any narcotic for the purpose of trafficking.

(3) Every person who violates subsection (1) or (2) is guilty of an indictable offence and is liable to imprisonment for life.

.
12. The Governor in Council may make regulations . . .

(d) requiring physicians . . . who deal in narcotics as authorized by this Act or the regulations to keep records and make returns; . . .

The regulations list the drugs which are to be deemed narcotics within the meaning of the Act, heroin being one of them.

As a result of this legislation, the price of narcotics, the normal cost of which is small, has risen so high that it attracts an endless procession of the lowest type of gangsters to keep the drug traffic flowing. Having, as a result of such legislation, made the illegal trafficking in drugs a very profitable business we then have to employ police to seek out, arrest and charge the gangsters who import the drugs. the pedlars who sell the drugs and the drug addicts in whose possession drugs may be

found. We must then employ judicial machinery to try these persons and build special institutions within which to hold the convicted drug addicts for the duration of their sentences—sometimes for life as habitual criminals. While we are incurring this very heavy expense with little probability under the existing system of effecting cures, the gangsters get rich, and the drug addict, a sick person, runs the risk of being sent to prison for being in possession of the narcotics which he believes he must have in order to survive.

We submit that the situation is very serious, and that we should make a further effort to reduce the present tragic waste of human beings and money by revising our thinking and introducing a more enlightened system that will make it unprofitable for gangsters to bring narcotics into Canada and sell them at huge profits—a system that will effectively control the present increasing consumption of narcotics and the number of addicts.

Pursuant to the Narcotic Control Act special facilities or institutions have been or are being created for the custody of drug addicts who have been convicted of having narcotics in their possession. It is intended that while they are in custody they will be given compulsory treatment for drug addiction; that they may be released on parole under supervision; that if they relapse they will be returned for further custody and treatment. Under the most favourable circumstances the cure of drug addiction is very speculative, and it seems to us to be a serious error to think that a compulsory cure program has any better chance of success. No matter how the institution where the compulsory treatment takes place is labelled, it will always be regarded as punishment by those who lose their liberty. Compulsion generates resistance and creates an environment unfavourable to cure and rehabilitation.

Now let us consider the position of the doctor. R. St. J. Macdonald, LL.B., LL.M., Professor of Law at the University of Toronto and a member of the Medical Advisory Board of

the Alcoholism and Drug Addiction Research Foundation, in his excellent article dealing with drug addiction, states:

If there is one problem in North America that continues to produce doubts, difficulties and confusion by lawyers, doctors, correctional and rehabilitation officers, social scientists and amateur observers of the passing scene, it is the problem of controlling and treating narcotic drug addiction. The addiction phenomenon is a great mystery, of course, and for that reason a variety of approaches is essential if we are to hope to comprehend it in the fullness of its manifestation. . . . We will probably have to prepare ourselves for a host of new approaches that have never been tested in this country; trying the British system of maintenance doses to help addicts to function and work; introducing half-way houses that have a quasi-family atmosphere in decent neighborhoods away from the addict culture, with its drug availability; intensifying efforts at vocational placement for the marginal addicts, and so forth.⁽¹⁾

. . . It is everywhere recognized that the physician should be involved in the addiction problem, and that, more specifically, he should be given greater responsibility and a larger role in treatment programs.

It seems to us that the development of a proper doctor and patient relationship between members of the profession and addicted persons, with the possibility of some personal help and supervision, is obviously desirable, and if in the opinion of the doctor this requires the provision of narcotics, preferably on a reducing dosage leading to final abstinence, we do not see why such a course should be criticized so long as it comes within the scope of sound medical practice. ■

I find the great thing in this world is not so much where we stand, as in which direction we are moving.

—OLIVER WENDELL HOLMES

(1) Addictions, Vol. 11, No. 1, Summer, 1964.

Question B.C. Physicians On Treatment of Narcotic Addicts

THE Narcotic Addiction Foundation of British Columbia recently sent out a questionnaire to 2,250 physicians in B.C. regarding the treatment of narcotic addicts. The results were reported by Dr. Robert Halliday, director of the N.A.F. as follows:

No. of replies to July 21, 1965.....	885
No. of physicians treating addicts.....	34
No. of physicians treating only through NAF	2
No. of physicians willing to treat addicts	182
No. of physicians willing to treat addicts only through NAF	12
No. of physicians unwilling to treat addicts but will refer to NAF	7
No. of physicians unwilling to treat addicts	613

Most of the physicians who gave a positive response lived in the Greater Vancouver area, where 9/10 of B.C.'s addicts live, and conversely the majority of those who stated their intention not to treat narcotic addicts worked in interior communities where they would seldom see any addicts (except possibly one who was in transit and would therefore not be present for any continuing therapy). Many of the latter also were specialists of various kinds who would not normally be consulted by an addict. The same is true for full-time hospital and clinic personnel, whether engaged in clinical practice or not.

In addition, during the last 2½ years or more, a total of 92 physicians in all have prescribed narcotic and other medications for addicts, the prescriptions being dispensed only at the Narcotic Addiction Foundation. A total of 822 such prescriptions have been filled. In the last three months (May, June and July, of 1965) 15 physicians have utilized the Narcotic Addiction Foundation facilities during their treatment of addicted patients. ■

Waiting Areas Can Aid Therapy

by J. D. Armstrong, M.D., D. Psych.
and Milo Tyndel, M.D., Ph.D.*

THE significance of informal and unofficial transaction between patients as individuals and groups on the one hand, and between them and members of the treatment staff on the other hand, although known for a long time, has been emphasized by Stanton and Schwartz,⁽¹⁾ Caudill⁽²⁾ and others. Recently, Rada, Draper and Daniels⁽³⁾ described their experience with a structurized utilization of a clinic waiting room as a therapeutic milieu, providing support and an opportunity to relate to others and practice in effective communication. The patients in which the beneficial effects of an accepting and anxiety relieving atmosphere of the waiting room area were observed, were described as suffering from a variety of psychotic and neurotic conditions, undergoing ambulatory supportive and suppressive psychotherapy. No mention was made of alcoholics and drug addicts.

Comprehensive Therapeutic Approach

In recent years, attempts were made in this clinic to establish a therapeutic community shaped partly after that originally described by Maxwell Jones.⁽⁴⁾ It is our belief that every part of the clinic as well as every member of the staff may play a therapeutic role, although in subtle and inconspicuous ways. In view of the complicated personality structure of the alcoholic and the drug addict, and of the complex nature of the emotional disturbances underlying their addiction, the multidimensional therapeutic approach which is facilitated by the therapeutic community setting, utilizes milieu therapy as intensively as feasible. Departing from the drab and uncomfortable waiting room

* Dr. Tyndel is a Senior Psychiatric Consultant with the Alcoholism and Drug Addiction Research Foundation in Toronto. The above article originally appeared in *Comprehensive Psychiatry*, Vol. 6, No. 2 (April), 1965.

setting in which alcoholics and addicts used to experience their first contact with treatment centers and in which they had to spend a considerable amount of time, the waiting rooms of this clinic were furnished and equipped fairly similarly to that described from the University of Chicago clinics and hospitals. The clinic co-ordinator, the receptionist, and members of the therapeutic and nursing staff mingle freely with the patients and a considerable amount of interaction can be observed both between the patients and the latter and the staff. The majority of the patients experience their time spent in the waiting room area as friendly and understanding acceptance in spite of a certain amount of discipline and submission to rules necessary for a smooth clinic operation, such as appointments, time table for group sessions, lectures, and activities, etc. Without catering too much to their dependency needs, the atmosphere surrounding the patients from the waiting room on gives their frequently weak or shattered ego the necessary support for improved functioning and cooperation in therapy. ■

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Care and Caricature For Soviet Alcoholics

An interesting two-column article on alcoholism in the Soviet Union was published in the July 21, 1965 issue of *Der Spiegel*.

According to this report most Soviet drinking is done at home. There are no pubs in Moscow and alcoholic beverages are sold in grocery stores.

A person found drunk is taken to the closest sobering-up station, which is apparently named in Russian, "Wytreswitel". The article tells something of the procedure at these sobering-up stations, where the drunken person is given a shower and gets a freshly made bed. The cost of this "hospitality" or "treatment" amounts to five rubles and the bill is sent to the employer of the person treated. This method usually causes unpleasant consequences for such a person, as his name may be published on the notice board at his place of work and he gets a special warning and may be demoted.

Der Spiegel suggests that this method is not always effective, and another approach is then tried with especially difficult drunkards. A kind of pillorying system is used, whereby the full names of notorious drunkards are published in the newspapers. Furthermore, in Moscow at railway stations and in such public places there are notice boards which carry pictures and names and addresses of such persons, including a caricature demonstrating the particular drunken situation in which he was apprehended.

As alcoholism seems to be a real problem in Russia, new ways are being explored to overcome the situation. The so-called "Comrade Courts", existing at the various places of employment, are given power to take away premiums and vacations from such violators and they may even order that his earnings be paid directly to his family. ■

(Translated by K. H. Wangerheim.)

A.I.T. Addictions

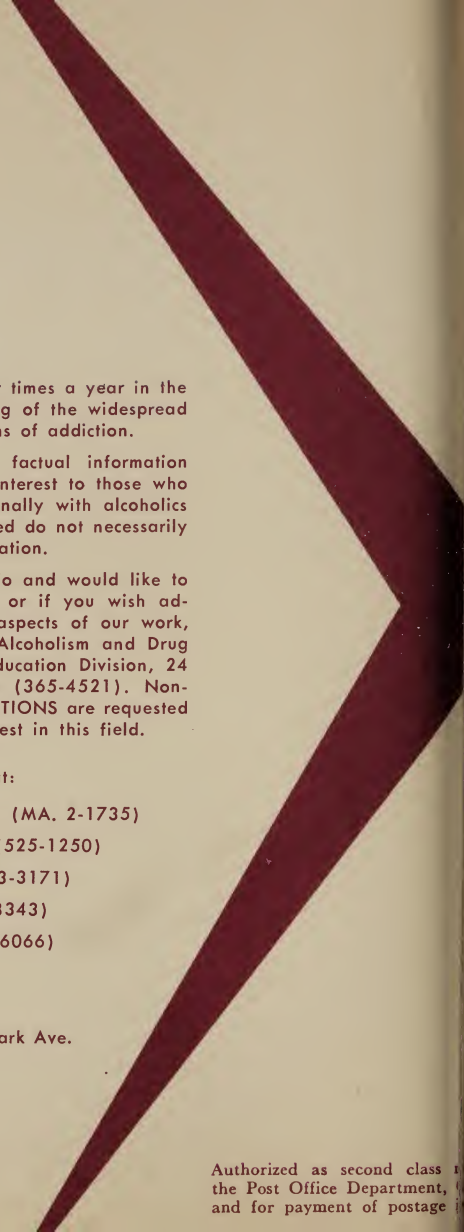
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This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you are a resident of Ontario and would like to receive this publication regularly, or if you wish additional information about some aspects of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Division, 24 Harbord St., Toronto 5, Ontario (365-4521). Non-residents wishing to receive ADDICTIONS are requested to indicate their professional interest in this field.

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A.I.T. Addictions

WINTER, 1965

SINCE Volume 1, Number 1 of this publication appeared more than 12 years ago, *ADDICTIONS* has repeatedly carried material about the education of young people with a view to preventing their dependency upon the effects of alcohol and other substances. Prevention through education is one of the chief goals laid down for the Alcoholism and Drug Addiction Research Foundation by the Province of Ontario. We've had quite a lot to say on the subject.

Like most people who take their teaching job seriously, however, we might properly be accused of saying too much, and of not listening enough. Consider, for instance, the following direct quotations from a number of senior high school students in suburban Toronto—

—From a 15-year-old boy: "Adults and kids have never been so far apart in their ideas."

—From a 16-year-old boy: "There is no one really close enough to know my inner problems."

—From a 16-year-old girl: "There is too much pressure on teen-agers, and most of it comes from the school and the teachers."

From a 16-year-old boy: "A person either has to solve his problems himself—or if he can't, he doesn't need an entire youth centre, but just one person who he can turn to."

Observes an understanding Head of Guidance: "These are teen-agers—clever, sensitive, anxious, discerning—reaching out to us. They want to understand and be understood, to love and be loved—they need adult help. Time and time again, in every home, in every school and organization, on every street corner and in every restaurant, they keep asking for attention, interest, respect. Often adults pretend they do not see or hear—until some undesirable incident causes too much of the wrong kind of attention." ■

The Influence of Alcohol on Mortality

*by Karl M. Davies**

IN 1950 Mr. Walter O. Menge presented a paper before the Home Office Life Underwriters Association on "Mortality Experience Among Cases Involving Alcoholic Habits." Over the intervening years this paper has been the definitive work on the subject and has formed the basis upon which many companies have constructed their underwriting rules for handling these cases. I have taken the liberty of making frequent reference to Mr. Menge's paper to compare results and to establish the validity of the relatively small study reported herein.

Alcoholism — Problem for Underwriter

We have been somewhat concerned over the adequacy and propriety of our habits ratings and have at long last produced a mortality study which, we hope, might provide some rating guidance. It has always been recognized that underwriting non-conformity in drinking is one of the most difficult problems an underwriter must face, for several reasons. Investigators have an exceedingly difficult time developing accurate and reliable descriptions of an applicant's habits. As a result, the underwriter is frequently faced with inconsistent and sometimes flatly contradictory reports. Still, these reports must constitute the basis for a fair decision. Beyond that problem lies the difficulty we all know an agent will have in placing a policy rated for habits, and the pressure which we receive from the field to rate more favorably. Frequently this pressure is accompanied by hair-raising statements from an agent or manager as to the applicant's suitability.

Specifics of Mortality Study

As for the specifics of our mortality study — it covers sub-standard medically examined insurance issued from 1940 to

* Mr. Davies is Vice-President, Underwriting Dept., Equitable Life Assurance Society of the United States, New York, N.Y. The above paper appears by Mr. Davies' permission.

1961 and observed to the 1962 policy anniversary. The only major impairment in these rated cases was non-conformity. In this respect our study differs somewhat from Mr. Menge's since his cases included ratable impairments other than habits, but where alcoholic habits was the most important underwriting factor. Another difference between our study and Mr. Menge's is that for us, exposure terminated when a policy rating was reduced to standard, while Mr. Menge kept such standard policies in the exposure. Our study included 2,582 policies with a total exposure of over 12,000 exposure years; there were 140 death claims. Since the number of female deaths was minimal, they were not separated. The expected claims were calculated on the basis of Equitable's contemporaneous standard medically examined crude mortality rates for the same issue ages and durations. This table of our own experience has a select period of roughly 15 years.

Summary of Results

To briefly summarize the results, there continues to be a substantial extra hazard (averaging two and one-half to three times standard) in underwriting habits cases. The mortality ratios show no remarkable change from those reported fifteen years ago for the classes which I can match. As for Equitable's rating practices, it appears that in general we have underwritten cases at a substandard class one or two levels lower (more favorable) than the subsequent experience would justify.

TABLE I

Impairment	Actual Claims	Expected Claims*	Mortality Ratio
No treatment or cure noted			
Last reported intoxication			
—within 2 years prior to issue	109	39.19	278%
—3, 4 or 5 years prior to issue	18	8.07	223
—more than 5 years prior to issue	5	1.92	260
Received treatment or took cure			
more than 2 years prior to issue	8	2.70	296
All	140	51.88	270%

* "Expected claims" refers to expected claims for standard lives.

The above Table I is a summary of the mortality experience for this group. You will note that the overall mortality ratio was 270 per cent. We do not have the large number of classes which were recorded by Mr. Menge. We show only two broad classes — those applicants who had received treatment or taken a cure at least two years prior to issue, and those who had not taken any treatment or cure. No effort was made to record the degree of intoxication or frequency of intoxication. (It was noted in Mr. Menge's paper that the mortality for the man who drinks to intoxication 52 times a year is practically the same as that for the man who becomes intoxicated only six times a year.)

Comparison of Mortality Levels

Some general comments are in order on the levels of mortality reported in 1950 and in this paper. To the extent that my classes can be compared with Mr. Menge's, the current mortality ratios are slightly lower than the earlier ones. This may be due to lack of comparability of the standard tables used to calculate expected deaths. I have not tried to develop that point because of the many other uncertainties in this field of underwriting. There are two factors which should lead to an expectation of higher mortality ratios in the Equitable study: (1) our exposure was terminated when a rating was reduced to standard and (2) our classifications shown in Table I include the high mortality spree drinking group which was classified separately by Mr. Menge. (On the other hand, our study should show better mortality results than Mr. Menge's because his study included ratable impairments other than habits.

One group which may be quite comparable is the class of applicants who have received treatment or taken a cure. Our mortality on those whose treatment or cure was at least two

years prior to application was 296 per cent. Mr. Menge's, for such applicants regardless of time period since treatment or cure, was 293 per cent.

The mortality ratios shown in Table I are surprisingly close together and certainly don't indicate any noticeable trends with respect to duration since last period of intoxication. Much of the same picture existed in 1950 where applicants whose drinking history was more recent (or current) did not show significantly worse mortality than those whose history dated back a few years. All the above leads to what seems like a very wild generalization, that habits cases regardless of frequency of drinking or the time since last intoxication produce mortality at 300 per cent of standard. Using Mr. Menge's data, the only exceptions to this gross rule would be the very serious spree drinkers who experience higher mortality and the steady free users who experience lower mortality. Incidentally, neither the 1950 study nor this one relates mortality to the extent of intoxication—i.e., boisterous—unsteady vs. stupefied and out-of-control.

Need Objective Data

Obviously we could not support a simple 300 per cent rating practice, but the data, both in 1950 and now, seem to recommend it. It seems inconceivable that this generalization truly reflects the facts. One is inclined to attribute this result to the inadequacies of our sources of information due to the recognized difficulty in obtaining true data on drinking histories. If all sources of information could provide our investigators with completely objective data, we could classify our risks better, and in time develop experience which could be refined. Since that is impossible, one must discount my wild generalization in developing rating tables, and intuitively give recognition to ill-defined and subjective aspects of the risk including extent of intoxication, how often intoxicated, and when last intoxicated. And in doing this one must also have in mind that any reported habits criticism is likely to be understated.

TABLE II*

Issue Age	Actual Claims	Expected Claims	Mortality Ratio
10 to 39	32	9.39	341%
40 to 49	44	18.52	238
50 and over	33	11.28	293
All	109	39.19	278%
Policy Year			
1 and 2	24	4.75	505%
3 to 5	21	8.01	262
6 to 10	26	10.60	245
11 to 15	22	9.56	230
16 to 22	16	6.27	255
All	109	39.19	278%

* This table is composed of that class in Table I where no treatment or cure had been noted, and the last reported intoxication occurred within two years prior to issue.

Analysis by Issue Age and Policy Year

The largest group in Table I, namely, the group in which no treatment or cure had been noted and the last period of intoxication having occurred within two years prior to issue, was further analyzed by issue age and policy year. Table II shows the results of that analysis. The current results bear some resemblance to the 1950 results. By age, somewhat higher mortality ratios are obtained for the younger issue ages than for the older issue ages; however, Mr. Menge's study showed a very definite trend with very high mortality (400-500 per cent) at younger issue ages grading rather smoothly to 100-200 per cent mortality at the oldest issue ages. By policy year, the degree of extra mortality among this group of lives was twice as great during the first two policy years as it was during subsequent policy years when it stayed quite level. Mr. Menge's study also showed significantly higher mortality in the early years, but it improved with duration rather than leveling off. Perhaps this results from our removing a case from the exposure once it had been reduced to standard.

TABLE III

Cause of Death	Actual Claims	Expected Claims For Standard Lives	Mortality Ratio
Malignant neoplasms	22	9.5	232%
Arteriosclerotic and degenerative heart disease	41	15.6	263
Other cardiovascular—renal diseases	10	4.6	217
Diseases of the digestive system	7	1.5	467
Motor vehicle accidents	9	1.8	500
Other accidents and homicide	7	1.6	438
Suicide	4	1.5	267
All other causes	9	3.1	290
	<hr/>	<hr/>	<hr/>
All causes	109	39.2	278%

Cause of Death Analysis

For the same group of 109 claims, we made a cause of death analysis which is shown in Table III. This comparison is somewhat approximate. It relates the mortality by the various causes of death to that which would have occurred among standard applicants. The ratios are high for all causes, whether or not related to drinking. It is rather interesting to note that the heaviest extra mortality arises in three categories — diseases of the digestive system, motor vehicle accidents, and other accidents and homicide. Four of the seven claims due to diseases of the digestive system were attributed to cirrhosis of the liver. (Incidentally, two of the claims shown under "All other causes" were attributed to alcoholism.) These results differ somewhat from Mr. Menge's, where abnormal causes of death were homicide, suicide, cirrhosis of the liver and heart disease.

A separate analysis of cause of death was also made for deaths occurring in the first two policy years because of the very high mortality ratios for those durations. In this study the same three causes of death—diseases of the digestive system, motor vehicle accidents, and other accidents and homicide — had a mortality ratio double that applicable to the entire group of 24 claims.

It was pointed out earlier in this paper that an analysis of the mortality results by substandard rating class indicates that

we were generally too liberal in our underwriting of these cases. In reviewing our underwriting practices over the years 1940 to 1961, we have found them to be fairly stable and rather well-reflected in the following table:

TABLE IV**

Frequency & Degree	Within Year	2nd Year	3rd Year	4th to 6th Year	7th Yr. & Later
1. Mild intoxication— to 12 times per year	50 to 0	0	0	0	0
2. Marked intoxication— to 12 times per yr.	150 to 50	75 to 30	50 to 0	0	0
3. Mild or marked intoxication over 12 times per yr.	D to 125	150 to 50	100 to 30	50 to 0	0
4. 2 or 3 day spree drinking— to 3 times per yr.	D	D to 150	150	150 to 75	50 to 0
5. 2 or 3 day spree drinking— over 3 times per yr.	D	D	D to 175	150	75 up
6. Steady free use— no intoxication	100	75	50	0	0
7. Cure or A.A. History	D	D	175	150	50*

* Total abstinence for 0 years or more—0 Debit.

** The figures in Table IV represent the debits that would be assessed for the frequency and degree of intoxication which are indicated. A numerical rating system is used in underwriting an applicant for insurance. This is a systematic method of measuring each of the factors which influence mortality, by the assignment of "debits" for those factors which are unfavorable and "credits" for those which are favorable.

It is assumed that the standard risk should receive a numerical rating of about 100, representing 100 per cent of the standard mortality table. In practice, each applicant is assumed initially to be standard and is given a rating of 100; then the debiting and crediting procedure comes into action. A total rating of say, 250 means that the insurance company expects the applicant to be subject to mortality rates two and a half times the standard rates. The total rating resulting from the debits and credits is then translated into a letter rating class.

The "D" in Table IV indicates that the debits needed to cover the risk would exceed the 500 per cent ceiling and the application would therefore be declined. Also in Table IV where the entry is a range such as "150 to 50", the poorer risks are assigned to larger debits.

Liberal Trend in Underwriting

Table IV is an adaptation of a table which has served as our guide over the years; the adaptation recognizes that we have generally underwritten on a somewhat more liberal basis than the guide table specified. Table IV contains more spread-ratings than the guide table, indicating the range in which the underwriter has exercised judgment in these cases. If there has been any trend in our rating practices during the years 1940 to 1961, it has been to liberalize somewhat in the use of the spread-ratings so that more cases may have benefited from the lower credits in recent years. But in reviewing death claim cases I have not found this particularly noticeable.

Of course, our guide table contains the usual caution to the underwriters to recognize quite a large variety of different factors in determining habits ratings, including the following: age; occupational grade; social habit of life; degree of intoxication; effect of intoxication—pugnacity, etc.; driving while intoxicated; physical or psychological impairment as either a cause or effect of drinking; and success of past efforts to cure himself of habit.

TABLE V

Rating Class	Actual Claims	Expected Claims	Mortality Ratio
B (145 or less)	16	9.00	178%
C (150 to 195)	70	27.85	251
D (200 to 245)	23	6.32	364
E (250 to 295)	5	2.03	246
F or G (300 to 500)	5	.22	2273
	<hr/> 119	45.42	262%

Table V shows our mortality experience in relation to the rating class assigned for the 119 claims which we could study by rating class. It can be seen that with the exception of the five cases which were rated "E," our mortality in each class was substantially higher than that assumed at the time of under-

writing. (In the latest study we made of general substandard mortality—letter ratings for all reasons—we found that mortality for the various rating classes generally fell nicely in the range assigned to the class.) Thus it seems clear that our habits ratings have been markedly more liberal than our ratings for other reasons.

Mr. Menge, in his study, did not relate their mortality experience to the underwriting classes assigned. However, he did point out that a separate study was made of cases issued standard despite habits histories. The mortality experience on these standard cases "showed a ratio of actual to expected mortality of 225 per cent . . . with 60 death claims. . . ."

Noting the mortality data in this paper, it is clear that drinkers have been getting a better underwriting "break" than subsequent experience has warranted. A review of cases does not develop any particular patterns that are out of line. It appears that the "break" springs from two biases in our system: it is likely that the sources of information our inspectors use will always understate the extent of drinking, past or present; and the apparent tendency on the part of underwriters to exaggerate in their judgment the more favorable aspects of a case.

Conclusions

This paper establishes that alcohol has a substantial influence on mortality which cannot be ignored or treated lightly in underwriting. Certainly, underwriting alcoholic habits is no less a problem today than it has been in the past. When we read articles in the press that there are 5,000,000 alcoholics in the United States today (as estimated by the Rutgers School of Alcoholic Studies), it may well be that our problem will be still more difficult in the future. ■

Alcoholism and Fatal Traffic Accidents

A STUDY IN FUTILITY¹

by *Melvin L. Selzer, M.D.*

and *Sue Weiss, M.S.W.*²

THAT a deadly epidemic is raging on our highways is by now beyond dispute. Well over a million lives have been taken by this epidemic since 1900 and if the present toll continues its upward spiral, another million persons will die of traffic injuries in the next 12 to 15 years. Although this paper will focus on driver aspects, it is not our intention to minimize the urgent need for safer car design and intelligent highway planning.

A number of studies have revealed a significant relationship between intoxicated drivers and automobile accidents, a relationship that tends to be more prominent with serious accidents.¹ Studies of fatally injured drivers indicate that approximately 50 per cent have blood alcohol levels of 0.15 per cent or higher with an additional 15 to 25 per cent of the drivers having lower blood alcohol levels^{4, 5}. Unfortunately, these studies do not reveal whether or not the fatally injured intoxicated drivers were chronic alcoholics, a question of considerable importance if we are to control a menacing public health problem.

The present study was undertaken to determine the incidence of chronic alcoholism in drivers responsible for fatal (non-pedestrian) traffic accidents. Although we have chosen to study drivers responsible for fatal accidents, it should be borne in mind that for every fatal accident that occurs, there are several others in which one or more persons survive only to suffer serious injury. The decision to limit the study to fatal accidents was based on several considerations. No one can question that fatal accidents are serious. A random study is insured because all fatal accidents are reported. Blood for alcohol determinations is readily obtained from deceased drivers since

1. The above paper was read at the 121st annual meeting of The American Psychiatric Association, New York, N.Y., May, 1965. It later appeared in *The Municipal Court Review*, September, 1965, Vol. 5, No. 3.

2. Department of Psychiatry, The University of Michigan Medical School, Ann Arbor, Michigan.

consent is not a problem. Lastly, we were aided by the fact that two medical colleagues were already investigating these fatal accidents for other reasons⁶. Thus far we have completed the investigation of drivers responsible for 72 fatal traffic accidents which claimed 87 lives. A control study of randomly selected drivers matched for age and county of residence with the study group drivers is now under way.

A word about the geographic locus of the study. Washtenaw County is largely rural with a population of 183,000. Ann Arbor, its largest city, has a population of 80,000 which includes 30,000 university students. However, two modern four lane expressways criss-cross the county and about 15 per cent of the fatal accidents occurred on these super-highways.

Method

All drivers responsible for fatal traffic accidents in Washtenaw County, Michigan, from October 29, 1961, through December 31, 1964, will be included in the study group. Excluded from the study were three fatally injured motorcyclists, accidents in which only pedestrians were killed, and four drivers who lived out of state. Some months after each fatal accident occurred, interviews were conducted with the driver's family, friends, employers, family physician and/or others who knew the driver. If the driver survived the accident, he too was interviewed. The interviews were informal but followed a general format to insure that certain questions would be asked. Our primary goal was to learn whether or not the driver was a chronic alcoholic. The number of interviews per case ranged from one to eight with an average of three interviews. We generally continued to interview in a given case until we were convinced that the driver was alcoholic or non-alcoholic or until there was no one left to interview. In addition to the interviews, we obtained copies of the driver's arrest record and driving record from the Michigan State Police and the Michigan Department of State, respectively.

General Data.—One of the 72 drivers responsible for a fatal accident, 64 were men; sixty-six were white, six were negro.

Only 13 (18 per cent) of the drivers survived the fatal accidents. Fifty (70 per cent) of the accidents were one car accidents involving neither other cars or pedestrians. Thirty-five (47 per cent) of the accidents occurred at night and one-half occurred between 6 p.m. Friday and 6 a.m. Monday.

Alcoholism — Our definition of alcoholism is a variation of that proposed by Keller⁷: Alcoholism is a symptom of chronic, emotional illness characterized by repeated drinking in amounts sufficient to cause injury to the drinker's health or to his social or economic functioning. In order to make the diagnosis, we used the criteria outlined by Guze, et al⁸.

Of the 72 drivers, 29 (40 per cent) were alcoholic, seven (10 per cent) were pre-alcoholic and 36 were non-alcoholic. Hence, at least one-half of the drivers had a serious drinking problem. It should be emphasized that these are minimal figures; we suspect that additional candor on the part of various respondents—or just additional respondents—would have increased the alcoholism group's size.

TABLE 1
Age of 72 Drivers Responsible for Fatal Traffic Accidents

Group	No. of Drivers	Age					
		16-21	22-30	31-40	41-50	51-60	61-73
Alcoholics	29	2	12 (41%)	8 (28%)	5	—	2
Pre-Alcoholics	7	4	2	1	—		
Non-Alcoholic	36	15 (42%)	6	5	5	4	1
Total	72	21 (29%)	20 (29%)	14 (19%)	10 (14%)	4	3

Age. — Most studies of serious automobile accidents reveal a disproportionately high number of younger drivers. This study is no exception but Table 1 reveals that whereas the 15 to 21 year old group is indeed over-represented in the non-alcoholic group, the predominant age period in the alcoholic driver group is the 22 to 40 year old group of drivers. This difference is not surprising since alcoholism is a syndrome that usually takes some years to develop to a point where it is discernible. One can only wonder if the younger group (15-21 year old drivers) in this study were destined to be tomorrow's somewhat older alcoholic fatalities had they lived long enough?

There were surprisingly few older drivers in the study group (Table 1). Of the three drivers who were 61 or older, two had been chronically alcoholic for many years.

TABLE 2
Drinking Status of 72 Drivers Prior to Fatal Accident

Group	No. of Drivers	Drinking	Not Drinking	Not Known
Alcoholics	29	28	1	—
Pre-Alcoholics	7	7	0	—
Non-Alcoholics	36	11 (31%)	24 (66%)	1
Total	72	46 (64%)	25 (35%)	1

Drinking and Driving — In this group of drivers, interviews and blood alcohol levels established that 46 (64 per cent) drivers had been drinking prior to the accident (Table 2). Only one driver in the alcoholic group was completely sober at the time of the accident (zero blood alcohol) whereas 24 (66 per cent) of the the 36 non-alcoholic drivers had not been drinking.

TABLE 3
Blood Alcohol of 36 Drivers After Accidents

Group	No.	.0-.09%	.10-.14%	.15-.46%
Alcoholics	21	1	3	17
Pre-Alcoholics	3	—	1	2
Non-Alcoholics	10	7	2	1
Total	34	8	6	20

We were able to obtain the blood alcohol of 36 of the drivers, usually within an hour of the time of the accident. Table 3 shows that all but one of the 20 heavily intoxicated drivers were alcoholic and pre-alcoholic. Only one of the non-alcoholic drivers had a blood alcohol level over 0.14 per cent compared with 19 (79 per cent) of the 24 drivers in the combined alcoholic and pre-alcoholic groups whose blood alcohol levels were known. In a previous paper, one of us (MLS) stated that a blood alcohol level in excess of 0.14 per cent was suggestive of alcoholism

n that it indicated the driver's approach to drinking was anything but casual⁹! The data in Table 3 tends to support that hypothesis.

Social Class. — We have long been intrigued by the social class distribution of persons apprehended for drinking-driving offenses. An earlier study of 67 persons arrested in Ann Arbor for driving while intoxicated, revealed that 80 per cent were in Hollingshead's¹⁰ classes IV and V⁹. At the time of that study, we were unable to decide whether the upper three social classes were less prone to alcoholism, drove less often when intoxicated, or drove more carefully even though alcoholic. We also considered whether the police and courts were biased in favor of drivers whose socio-economic positions reflected status and achievement. The present study provides a very tentative answer to the above speculation. Of the 72 drivers in the current study, 77 per cent were in social classes IV and V. If we consider only the 46 drivers known to be drinking, then 72 per cent are in classes IV and V. Of the 36 alcoholic and pre-alcoholic drivers, 83 per cent were in classes IV and V. Since the grim reaper cannot be accused of bias, at least not in regard to fatal accidents, we have some indirect evidence that police prejudices may not be a significant factor in the high incidence of drivers from the lower social classes who are apprehended following alcohol-involved traffic violations and accidents.

Psychiatric Diagnosis. — At least 42 drivers (58 per cent) suffered classifiable psychiatric illness exclusive of alcoholism. This includes the 29 alcoholics who were further diagnosed: passive-aggressive personality-17; sociopathic personality-six; there was also one alcoholic driver in each of the following categories: depressive reaction, emotionally unstable personality, paranoid personality, homosexual, chronic brain syndrome (trauma), and depressive reaction.

There was less detectable psychiatric illness in the 36 non-alcoholic driver groups; only 13 (32 per cent) were so categorized: passive-aggressive personality-seven; sociopath-two; depressive reaction-one, homosexual-one, chronic brain syndrome (senile)-one, schizophrenia-one.

TABLE 4

Relevant Symptoms in 72 Drivers Responsible for Fatal Accidents

Group	No. of Drivers	Thinking Paranoid	Suicidal Thoughts/Acts	Depression	Violence
Alcoholics	29	15 (52%)	4 (14%)	8 (28%)	8 (28%)
Pre-Alcoholics	7	0	1	0	0
Non-Alcoholics	36	4	2	6	1
Total	72	19 (26%)	7 (10%)	14 (19%)	9 (13%)

Specific Types of Psychopathology.—An earlier study of alcoholic drivers correlating specific symptoms of emotional illness with high traffic accident involvement has unexpectedly revealed that paranoid thinking in the alcoholic was the symptom most highly correlated with traffic accidents¹¹. Hence we sought evidence of paranoid ideation in the drivers that comprised this study. We were also interested in any recent history of serious suicidal preoccupation or past suicidal attempts, significant depression, or history of uncontrolled physical violence. Table 4 shows that paranoid ideation was again a prominent finding in the alcoholic drivers. Often these men (and one woman) would entertain paranoid thoughts only when drinking—not infrequently about their wives being with other men.

As seen in Table 4, a significant number of alcoholic drivers suffered depression or had attempted suicide or seriously considered it.

We were quite impressed with the extreme violence of some of these men, again a phenomenon that usually occurred after they had been drinking. These "violent" drivers had recurrent histories of assaults upon other persons, not infrequently friends or relatives, in which they or their adversary would be severely beaten.

Previous Accidents and Violations.—Since we do not as yet have a control group to compare the "fatal" group's prior traffic history with, a few general remarks will suffice. The alcoholic and pre-alcoholic drivers averaged 1.7 accidents and 3.5 moving violations each prior to the fatal accident compared to 0.8 accidents and 1.8 moving violations for the non-alcoholic

drivers. We also tried to determine the number of prior major accidents each driver had caused. We defined as "major" those accidents in which the: (a) vehicle overturned, (b) vehicle was demolished or (c) the passengers required medical attention. Our results here are impressionistic because we could not always obtain details of accidents that occurred many years before. The 36 alcoholic and pre-alcoholic drivers averaged 0.7 prior major accidents each whereas the 36 non-alcoholics were responsible for but one such accident (0.3 major accidents per driver). One grim detail was the fact that two of the 29 alcoholic drivers had been responsible for a previous traffic death while they had been driving in an intoxicated state.

Of particular interest was the number of prior convictions for intoxicated driving. Eight of the 29 alcoholic drivers compiled 17 such convictions (three drivers had one intoxicated driving conviction, three had two and two men had four) whereas the seven driver pre-alcoholic group had one as did the 36 driver non-alcoholic group.

Non-Traffic Arrests Involving Alcohol.—Ten of the 29 alcoholic drivers had been convicted of drunk and disorderly behavior at least once. Five had one such conviction, two had two, two had three and one man had four. (Only one driver in the 36 person non-alcoholic group had a similar conviction). In all, the arrest records of the 29 alcoholics revealed that 13 (45 per cent) had had either a drunk driving or a drunk and disorderly conviction. We cite this statistic because this information is a matter of public record — and any conviction based on the abuse of alcohol should alert authorities to the possibility they are dealing with an emotionally ill, alcoholic individual.

Discussion

Why have we entitled this presentation "Study in Futility"? It is becoming clear to us that a substantial number of alcoholized drivers who precipitate grave traffic incidents are chronic alcoholics. It is equally clear that arrests and penalties for drunk driving or drunk and disorderly offenses do not protect the

driving public. Suspending or revoking the driver's license is also a dubious gesture; three of the 72 drivers described here were driving without a license at the time they caused a fatality. Thirteen had been cited at least once for driving while their licenses were revoked. Nor does lack of license prevent a driver from purchasing a car. One of our alcoholic subjects came to Michigan from an adjoining state where he had just been released from a state mental hospital having undergone treatment for habitual alcoholism. He never had a license but did have three drunk driving convictions. He promptly purchased a car and wrecked it a few weeks later while driving in an intoxicated state. His passenger, a young woman, was killed and two other passengers injured.

Since many alcoholic drivers are immunized by their illness against the usual type of legal threats and educational campaigns — and also appear to be responsible for the overwhelming majority of serious alcohol-involved fatal traffic accidents, it behooves us to take remedial action. An epidemic requires that quarantines be imposed and the victims treated. The alcoholic driver today, even when repeatedly apprehended, is neither effectively restricted from driving nor required to seek treatment. The result is that he continues his depredations until he removes himself by way of a fatal injury. This places other drivers in positions much like that of ducks in a shooting gallery.

Present methodology has proved futile in reducing serious and fatal alcohol-related traffic accidents because of failure to appreciate that many drivers responsible for these events are decidedly atypical in that they are addicted to alcohol and prone to act out in a violent or suicidal manner. Some 48,000 Americans will die in traffic accidents this year. An identifiable group of alcoholic drivers will account for approximately one-half of these deaths. It is time that preventive measures be developed and introduced.

Summary

Of 72 drivers responsible for fatal traffic accidents in Washtenaw County, Michigan, 29 (40 per cent) were alcoholic, seven

(10 per cent) were pre-alcoholic and 36 (50 per cent) were non-alcoholic. Hence one-half of the drivers had serious drinking problems of a chronic nature. Of the 46 (64 per cent) drivers known to have been drinking prior to the fatal accident, 35 (75 per cent) were alcoholics or pre-alcoholics.

Many of the 29 alcoholic drivers had a long history of serious psychopathology which may well have contributed to their accident-susceptibility. They were frequently paranoid (52 per cent), violent (28 per cent), depressed (28 per cent) and suicidal (14 per cent.)

The records revealed that 13 (45 per cent) alcoholics had at least one prior arrest for drunk driving or drunk and disorderly conduct, and three had long since had their licenses to drive revoked. In addition, the alcoholic drivers were responsible for significantly more prior serious accidents and moving traffic violations than the non-alcoholic drivers in this study. Two of the alcoholic drivers had killed other persons in prior traffic accidents while driving in an intoxicated state.

This study demonstrates that an identifiable group of alcoholic drivers was responsible for approximately one-half of the fatal accidents. Many serious traffic accidents are caused by alcoholic, intoxicated persons whose illness immunizes them against present deterrents. Only a program designed to detect, restrain, and rehabilitate the alcoholic driver will protect us from the "inevitable" which are now mislabeled "accidents".

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Victorian Oblivion

by Ronald Pearsall

NO account of Victorian drug addiction is complete without reference to Thomas de Quincey, whose *Confessions of an English Opium Eater* set the tone of boastful self-satisfaction that is prevalent throughout the century. Although de Quincey lived far into Victoria's reign, his *Confessions* came out in 1821 and established a vogue amongst the Regency fast set for drugs, and particularly de Quincey's specialty, laudanum.

It is often forgotten that the Victorian age was one primarily of adventure and experiment, invention and innovation. This resulted in a good deal of ill-advised dabbling. Laudanum, it was decided, was the panacea for every ill. It was also fairly cheap: in the early years of the last century, East Indian opium (laudanum is a fluid extract of opium) was three guineas a pound, Turkish opium eight guineas.

Laudanum was considered particularly suitable in the treatment of diarrhoea and coughs, it soothed frayed nerves, and it was believed to ward off consumption. The last was its strongest selling-point; as late as 1880, consumption killed 14 per cent of the population. In 1860, it killed over twice as many people as any other disease (2,730 per million each year). Any cure for consumption was therefore eagerly welcomed.

In most cases, laudanum was taken initially for a specific ailment. De Quincey had acquired some rather dramatic rheumatic pains in the head and face, and for 10½d. he obtained from a chemist in Oxford Street a sufficient helping of opium to "hook" him for life.

19th Century Defence of Addiction

A characteristic of the 19th century was the resolute de-

The above article originally appeared in the August, 1965 issue of *HEALTH*, the magazine of The Chest and Heart Association, London, England. It is reprinted here by permission of both editor and author.

ence of the chosen oblivion. At his peak, de Quincey was taking 53 ounces of laudanum a day, and comparing wine unfavourably with it. "Whereas", he wrote, "wine disorders the mental faculties, opium, on the contrary (if taken in a proper manner), introduces amongst them the most exquisite order, legislation, and harmony."

There is no mention here of the withdrawal symptoms — 'yawning, sneezing, lacrimation, a running nose, goose flesh, rapid pulse, sexual orgasm, increased blood pressure, dilated pupils, hot and cold flushes, nausea, vomiting, loss of appetite, weight loss, and muscular twitches'. Surely de Quincey would have been acquainted with this imposing roll-call of inconveniences? Apparently not. Brightly he wrote: "For ten years, during which I took opium at intervals, the day succeeding to that on which I allowed myself this luxury was always a day of unusually good spirits."

A Typical Addict

The romance of opium straddles the age right up to Edgar Wallace and his opium-smokers of Limehouse. Those introverted figures who suffered in silence from a pragmatic and materialistic society envied the easy escape. One of these embryonic literary men impressed by the fact that de Quincey and the great poet Coleridge took laudanum was Branwell Brontë, brother of the talented Brontë sisters (Emily wrote *Wuthering Heights*, Charlotte wrote *Jane Eyre*). If de Quincey could take 53 ounces of laudanum a day, Brontë considered, he surely could manage three? Apparently not. Although laudanum was eminently suited to a father-oppressed household like the Brontës the whole project of taking drugs was not so innocent as the century supposed.

Branwell Brontë may have become a literary figure of some account but for drugs, which he afterwards combined with gin. In the event, he was a tutor, a feckless station-master, and a professional failure who dabbled in lachrymose verse. He fits in perfectly with the "Pharmacological Basis of Therapeutics"

strictures on the addict 'The vast majority of addicts are persons classified as neurotic or constitutional psychopathic inferiors, and addiction is only one manifestation of their fundamental personality defect . . . the drug provides an escape mechanism from reality.'

Medicine Allied to Magic

In the middle years of the century, medicine was more allied to magic than to chemistry; there was an element of strangeness, and sometimes fear. In the letters of Jane Welsh Carlyle, perhaps the most unlikely of all Victorian ladies to become a drug addict, we see an almost obsessive curiosity in new medical discoveries. In 1857, she writes to a friend whose father is a doctor:

"Does your Father prescribe Pepsien in stomach complaints? Has he ever seen the blessed thing? Ever heard of it? This Pepsien (I don't know if I spell it right; but as the word is made out of dispepsia without the dis, I can't be very far wrong) is just the very latest caprice in Medicine; that's all! It is something scraped off the inside of people's stomachs (dead the people must be before one can conveniently scrape their stomachs!)"

We can see by this that the public interest in medicine is considerably older than the advent of TV's "Emergency Ward Ten", or "Doctor Kildare". The Victorian was aware, however dimly, of new dimensions in medicine; pain, they decided, did not necessarily come from God. The century is sparkled by discovery; the composition of chloroform was ascertained in 1835, and it was used in Edinburgh in 1847. In the 1830's two natural alkaloids from opium, morphine and codeine, had been isolated. In the 1840's, the evolution of the hypodermic needle by Alexander Wood made the intravenous assimilation of drugs possible, though laudanum remained the happy way of taking drugs, until the widespread use of chloral hydrate,

introduced by Liebreich in 1869. Chloral hydrate became the most persuasive drug of the second half of the 19th century, and acquired its quota of addicts, the most famous of which was the poet-painter Rossetti, whose wife had been a laudanum addict, under the influence of which she probably committed suicide.

A Powerful Hypnotic

By the '60's the hazards of laudanum were well known, and few people believed that it was the answer to consumption. Chloral hydrate, it was believed, was free of laudanum's fatal charm, just as heroin was hailed in 1898 as "a drug of increased effectiveness with decreased addiction liability". Chloral hydrate was "a powerful and safe hypnotic, acting directly on the brain, and producing no preliminary stage of excitement. Very soon — perhaps 20 minutes — after taking such a dose, the patient falls into a sleep which lasts several hours and is not distinguishable from natural sleep."

Chloral hydrate was prescribed for the insomniac and the neurasthenic. When sunlight and artificial light made Rossetti dizzy — hypersensitivity to light marks off the neurotic artist — he turned to whisky with chloral. He became the victim of persecution feelings, reaching a peak in auditory hallucinations in which a voice called out to him "a term of gross and unbearable obloquy". Upon this, Rossetti drank a bottle of laudanum, went into a coma, while a doctor diagnosed "effusion of serum of the brain".

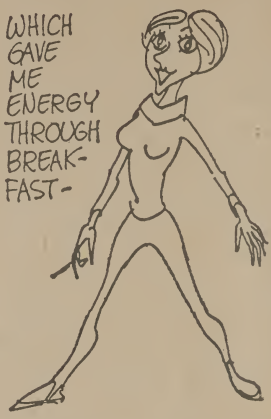
At this period, checks on chemists were ineffective; from his supplier in the Charing Cross Road, Rossetti was purchasing 12 bottles of chloral every eight or nine days. His friend, the novelist Hall Caine, described chloral as "the blessed discovery that was to save him from days of weariness and nights of misery and tears".

Even drugs can be sentimentalized over. ■

EVERY MORN-
ING BEFORE
LARRY COULD
SEE ME
DEAD AND
BLOWSY I
DRAGGED
OUT OF BED
AND TOOK
100 MG.
OF SPEMO-
CLAGULATE--



WHICH
GAVE
ME
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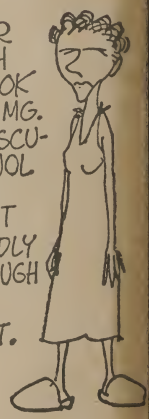
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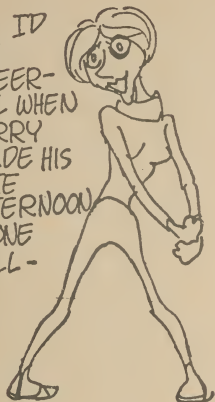
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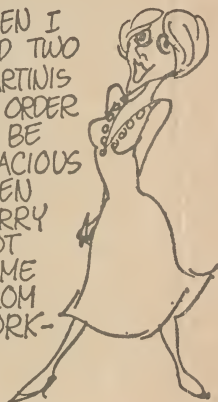
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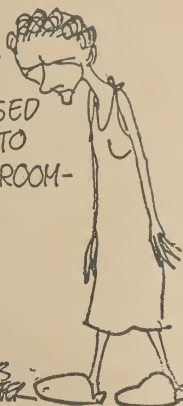
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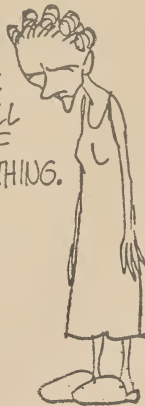
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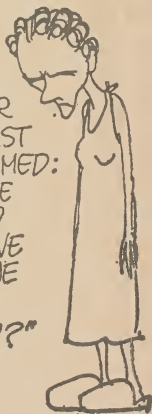
THIS
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WOKE
UP DRAGGED
MYSELF TO
THE BATHROOM -



AND
FOUND
THAT I
WAS ALL
OUT OF
EVERYTHING.



WHEN
LARRY
CAME
DOWN FOR
BREAKFAST
HE SCREAMED:
"WHO ARE
YOU AND
WHAT HAVE
YOU DONE
WITH
DOROTHY?"



Words, Wisdom and Wiseacres

PROVERBS are a kind of distilled folk wisdom; and like some other distillates may at times seem strong to the taste and confusing to the mind. Taken singly and savored — if they appeal to the taster — such epigrams can be heady and illuminating; but, again like strong drink, they are not recommended in great quantity at one swallow, nor in indiscriminate mixtures.

What follows, then, is an assortment to be sipped slowly and not to be gulped down at a single sitting. The best way to read what follows is to cast the eye lightly over the italicized phrases until one catches . . . then later another . . . and another. All will not appeal to everyone; but some in the collection that follows will surely hit the mark with every reader. No doubt some of these will already sound familiar, while others will become familiar as they are picked up and quoted or paraphrased by after-dinner speakers and lecturers of the future.

Here, then, is a sampler of proverbs related to drinking, as compiled by Dr. H. Pullar-Strecker, a psychiatrist who has pioneered in the treatment of alcoholism in England. Dr. Pullar-Strecker was asked by the late Dr. E. M. Jellinek, shortly before his death on October 22, 1963, to prepare a short paper containing representative proverbs about strong drink. Dr. Pullar-Strecker has kindly consented to the publication of his paper in *ADDICTIONS*.

Proverbs being the subject, we must bypass the hundreds of expressions our language has for "drunkenness" and "being drunk", as well as everyday phrases borrowed from the world of drink, such as "Life is not all beer and skittles". Proverbial lore embraces proverbs, phrases, sayings, wordplays, the distinction "proverb" being reserved for a terse, virile, colourful summing-up of a simple truth of life, such as *WINE IN, WIT OUT*. Cast in a jocular vein, a saying such as *HE WAS HANGED THAT LEFT HIS DRINK BEHIND HIM*, has not the force of the proverb: *BETTER BELLY BURST THAN GOOD DRINK LOST*.

When a man quits his friends too early and will not stay to finish the bottle, he is sure to have this remark thrown at him. *HE WAS HANGED . . .* The story behind this popular saying runs that a saddler of Bawtry, Yorkshire, on the way to the gallows, refused to stay for the customary drink and so by a few minutes missed the reprieve that was being sent after him. However this may be, it was always reprehensible to leave drink unconsumed.

Drink is the best physic

Ale, and beer, being the Englishman's drink first and foremost, is praised above all others: *GOOD ALE IS DRINK, MEAT, AND CLOTH*, and *BREAD IS THE STAFF OF LIFE, BUT BEER IS LIFE ITSELF*. Small beer, however (a thin, light brew) miscalled *WATER BEWITCHED*, was spoken of disparagingly as *SUCH DRINK AS WILL KEEP ONE IN THE RIGHT WAY*, i.e., sober.

Cider, potent enough, was very popular but feared for its cantankerous after-effects, hence *CIDER IS A TREACHEROUS DRINK BECAUSE IT SMILES IN A MAN'S FACE AND THEN CUTS HIS THROAT*.

Wine, of course, *THE BEST BROOM FOR TROUBLES*, is good for everything: *IN WINTER FOR COLD, IN SUMMER*

FOR HEAT, it WHETS THE WIT, ENGENDRETH GOOD BLOOD, DRIVES OUT BAD THOUGHTS, and MAKES GLAD THE HEART OF MAN.

Savings on spirits are scarce; I can find only this one: *SIR JOHN BARLEYCORN IS THE STRONGEST KNIGHT*, a compliment it shared with strong ale.

Digestion

Of precepts on digestion, there is nothing to touch the French *AFTER A PEAR, WINE OR THE PRIEST*, while rhyme seems to dominate reason in the Spanish: *AFTER A MELON, WINE IS A FELON*.

English, French and Spanish sayings agree that milk should come before and not after wine; hence *MILK SAYS TO WINE, WELCOME FRIEND*. Also, beer should come before wine and cider, viz. *CIDER UPON BEER IS VERY GOOD CHEER, BUT BEER UPON CIDER'S A RIDER*. Again, one does not know how much to attribute to rhyme, and how much to the vagaries of cider.

Thirst-raisers

There are several, such as *A HERRING IS A SHOOING HORN TO A POT OF ALE*. Another, mere wordplay: *GARLIC MAKES A MAN WINK, DRINK, AND STINK* serves to set off the colourful *SALT BEEF FINDS THE WAY TO WINE WITHOUT A CANDLE*, perhaps the most satisfying one in our collection.

Water

Though some proverbs advise moderation such as the glorious Spanish *DRINK WATER LIKE AN OX, AND WINE LIKE A KING*, their general attitude is the fatalistic: *DRINK WINE*

AND HAVE THE GOUT; DRINK NO WINE AND HAVE THE GOUT TOO.

There are countless drinking songs but few on the joys of water-drinking. So with proverbs: the Italian *WATER MAKES ONE ILL, WINE MAKES ONE SING*, the grumpy Scottish: *I NEVER LIKED WATER I'MY SHOON, AND MY WAME'S* (belly's) *MADE O' BETTER LEATHER*; and the elegant Spanish: *WINE HAS TWO FAULTS: IF YOU ADD WATER TO IT, YOU RUIN IT, AND IF YOU DO NOT ADD WATER TO IT, IT RUINS YOU*.

Venus

Turning to "Venus", we find many robust sayings in the nature of *WINE MAKES OLD WIVES WENCHES*. Many stress the sting: *WINE GIVES US LIBERTY, LOVE TAKES IT AWAY*, but hardly any support Dr. Martin Luther's "Wine, women and song". Even the comfortable Russian: *UP TO THIRTY, WARMTH FROM A WOMAN; AFTER THIRTY, WARMTH FROM WINE* has no such ring.

Thirsty Trades

The proverb loves thirsty trades, the smith's, cobbler's, piper's, miller's. The cobbler — so thirsty from the force of drawing through the thread, perhaps with his teeth — is its especial favourite: *COBBLERS AND TINKERS ARE THE BEST ALE-DRINKERS*, above all on the day of St. Crispin (their Patron Saint): *ON THE FOURTEENTH OF OCTOBER, THERE WAS NE'ER A SOUTER SOBER*.

THE SMITH, so it goes, *HATH ALWAYS A SPARK IN HIS THROAT*. His prowess extends to his dog: *LIKE THE SMITH'S DOG, SO USED TO SPARKS THAT HE'LL NOT BURN* is said approvingly of someone with a good head for

drink. Too good a head, however commendable in a lord, is not for the workman. Both the Russian *GOLDEN HANDS, BUT A WICKED MOUTH*, and the English *HE HAS A HOLE UNDER HIS NOSE THAT ALL HIS MONEY RUNS INTO* are vividly descriptive, while the Scottish *HE MAY WRITE TO HIS FRIENDS* tells that he will get but little sympathy, poor fellow.

One for the Road

The aristocratic *A SPUR IN THE HEAD IS WORTH TWO IN THE HEEL*, and *A CUP IN THE PATE IS A MILE IN THE GATE* (-way) reflect life in the saddle in Merrie Olde England when it was no shame to be "as drunk as a lord". These equestrian proverbs of 300 years or more invite wider application, in the sense of: "Provide in leisure to use in haste", or "Who has no understanding, let him have legs".

Conversely, the dull *WHO DRINKS A LITTLE TOO MUCH DRINKS MUCH TOO MUCH* applies to our motoring age.

At Another Man's Cost

Scores of phrases extol "the wild, rapturous pleasure" of drinking at another man's cost. From England comes *NEIGHBOUR QUART IS GOOD QUART*, from France *BOIRE COMME UN FIANCÉ* (probably derived from Penelope's rapacious suitors), from Bulgaria *WHO GETS DRUNK ON CREDIT GETS DOUBLY DRUNK*, contrasted, or perhaps confirmed, by the Spanish *NO ONE GETS DRUNK WITH HIS OWN WINE*. And from Russia this excellent piece of advice: *IF YOU WANT TO BE FED WELL, SIT NEXT TO THE HOSTESS; IF YOU WANT TO GET DRUNK, SIT NEXT TO THE HOST*.

A different tale: *I'LL TAKE A STANDING DRINK LIKE TO COW OF FORFAR* goes to show that the present Anglo-

American habit of "perpendicular" drinking cannot be very old. The story goes that a woman of Forfar, Scotland, put her soup out to cool when a cow came and drank it up. The cow's owner was sued for damages but was acquitted since the cow "took but a standing drink".

A fascinating subject for research: compare and contrast development of alcoholism in "sitting" and "standing" countries.

What Soberness Conceals, Drunkenness Reveals

The classical: *THOUGHT WHEN SOBER, SAID WHEN DRUNK* recurs in all languages, in many variants, the Scottish *PINT STOUPS* (-jugs) *HAE LANG LUGS* (-ears) demonstrating! why *ALE-SELLERS SHOULD NOT BE TALE-TELLERS*.

Equally ancient *IN VINO VERITAS — WINE IN, TRUTH OUT*. Drink is a telltruth and has always been used as such, so the grand Hungarian: *GIVE HIM TO DRINK AND YOU WILL SEE WHOSE SON HE IS*. Similar the English *WINE WASHES OFF THE DAUB AND DISCOVERS THE MAN*, and the Russian: *DON'T ASK WHETHER HE DRINKS, BUT ASK WHAT MAN HE IS WHEN DRUNK*. In Finland it runs: *THE ANVIL PROVES* (-tests) *THE IRON, THE DRINK THE MAN*.

Shakespeare's "Great men should drink with harness on their throats" applies all round, for *WHEN WINE SINKS, WORDS SWIM. COUNSEL OVER CUPS IS CRAZY*, therefore, and since *EVERYONE HATES A POT COMPANION WITH A GOOD MEMORY*, we are advised: *CHOOSE THY COMPANY BEFORE THY DRINK*.

Bacchus Drowns More Than Neptune

Proverbial lore, though out to praise drinking, is not, as we have seen, blind to its dangers. The slippery slope starts with

EATING AND DRINKING WANT BUT A BEGINNING, goes on to: *IT IS ONLY THE FIRST BOTTLE THAT IS DEAR*, then comes *WINE IS A TURNCOAT, FIRST A FRIEND AND THEN AN ENEMY*, followed by the Japanese: *FIRST THE MAN TAKES A DRINK, THEN THE DRINK TAKES A DRINK, THEN THE DRINK TAKES THE MAN*, and finally the unfeeling Hebrew: *LET BUT THE DRUNK-ARD ALONE AND HE WILL FALL OF HIMSELF*.

In conclusion, I offer my colleagues three favourite prescriptions: the shrewdly diagnostic Danish *YOU CANNOT DISTINGUISH BETWEEN A MAN DRUNK AND A MAN MAD UNTIL THEY HAVE SLEPT*, the all-too true Russian: *ONE DOES NOT GET A HEADACHE FROM WHAT OTHER PEOPLE HAVE DRUNK*, and the equally true, also from Russia: *IF THE HUSBAND DRINKS, HALF THE HOUSE IS ON FIRE; IF THE WIFE DRINKS, THE WHOLE HOUSE IS ABLAZE*. ■

Ontario Physicians View the Addict Patient

*by Vernon Lang**

ALTHOUGH addiction to alcohol and other substances has gradually become recognized as a problem of illness rather than of crime or immorality, there has been little unanimity within the medical profession as to the extent to which such treatment could be carried on in the ordinary course of private practice.

With this in mind, an exploratory, one-page questionnaire (two sides) was sent to 8,200 Ontario physicians, by the Addiction Research Foundation, in cooperation with the Ontario Medical Association. The response of 1,689 replies was just over 20 per cent. A summary of the replies follows:

Prevalence of Addictions in Patient Loads

The physicians were asked how many patients with various addictions they would see in the course of a year. The answers from 1,678** physicians are summarized in Table I.

* Mr. Lang is Special Projects Officer with the Alcoholism and Drug Addiction Research Foundation.

** From the sample of 1,689 physicians, 11 were eliminated in this particular Table in order to avoid distortion by extreme cases.

TABLE I

Substances to which Patients Addicted	Physicians Reporting Patients with Various Addictions Number	Total Number of Addicted Patients
Alcohol	1,234	11,855
Barbiturates	762	3,198
Amphetamines	355	944
Narcotics	160	370
Tranquillizers	44	147
Other or unspecified	37	53
		<hr/> 16,567

TABLE II

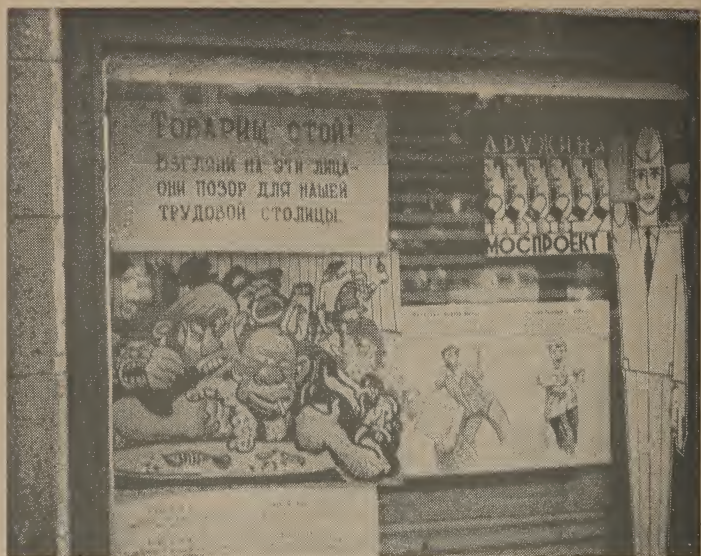
The 160 physicians reporting addicts to "narcotics or their compounds" in Table I were as follows:

Drug of Addiction	Reporting Doctors	Addicted Patients
Demerol	61	112
Codeine and its compounds	32	74
Morphine	34	51
Heroin	9	25
Other or unspecified (narcotics)	41	108
		<hr/> 370

It appears, then, that about three-quarters of all physicians (including specialists) have some professional contact with several alcoholics during a typical year; that nearly half of all physicians encounter some barbiturate addicts; and that one-fifth encounter amphetamine addicts. Narcotic and tranquillizer addicts rarely appear in an average private practice.

Sixteen per cent of the doctors said that they themselves treated their alcoholic patients, 24 per cent said they referred such patients elsewhere, 31 per cent did both, and 29 per cent either said they "do nothing" about alcoholic patients or they did not answer the question.

With regard to drug addiction, it is clear that narcotic and tranquillizer addictions only very rarely present themselves to the average physician, but that amphetamine and especially barbiturate addictions present themselves far more frequently than most people had realized. While narcotic addiction may therefore very well remain a sphere for specialists only, the professions in general will need to be concerned about the treatment of addictions to non-narcotic drugs.



"Comrade, stop! Look at these people. They are a disgrace." Notice boards in public places in Moscow carry condemnations of alcoholics, along with names, addresses and caricatures of the situation at time of arrest. This is all part of the treatment described in an article on alcoholism in the Soviet Union, published in *Der Spiegel* and translated for *ADDICTIONS* by K. H. Wangenheim in the Fall, 1965 issue (page 48).

Drugs and Driving

ALTHOUGH there are no statistics proving that drugs contribute substantially to the over-all accident rate, there can be no doubt that drugs do, upon occasion, contribute to accidents. It is obvious, for instance, that the abuser of certain drugs is going to be a traffic hazard.

From a physiological point of view, driving a car or a truck is a highly complex activity. A wide variety of physical and mental functions must be coordinated by the driver's central

The above article is reproduced with the permission of Smith Kline and French Laboratories from their manual, "Drug Abuse".

nervous system. Unfortunately, the human central nervous system is most sensitive, and any drug which has an effect on the central nervous system (and literally thousands of drugs do) physician can also have trouble with driving.

Driving Under Medication

While the drug abuser or "thrill seeker" creates a recognizable problem, the normal citizen taking drugs prescribed by his physician can also have trouble with driving.

Many drugs, taken solely for medical reasons, can cause deficient driving. The sedatives and hypnotics—often administered to induce sleep—are obvious examples. Some tranquilizers also cause drowsiness, as do the antihistamines, taken for hay fever and allergy problems. Alcohol will potentiate the sedative effects of depressants, including certain tranquilizers. Some stimulant drugs produce tremor, instability, dizziness and combativeness. In large doses, they may produce hallucinations. Very occasionally, the anti-infective drugs (antibiotics and sulfas) may cause dizziness, drowsiness, nausea and vomiting, and mild euphoria.

On the other side of the picture, it should be noted that drugs can often improve a driver's performance. For instance, the tense, aggressive driver may become less accident-prone under suitable tranquilizing medication.

Awareness — An Effective Remedy

It has been estimated that at least ten per cent and perhaps as much as 20 per cent of the people of driving age are taking medication resulting from a doctor's prescription at any given time. This figure omits the many millions of people who are under self-medication (with drugs legally available without a doctor's prescription). Obviously, any attempt to "police" the legitimate and necessary taking of medicines would be impractical. Only an awareness by physicians and the public of the possible dangers in driving after taking certain drugs will be an effective remedy. ■

How to Be a Normal Neurotic

by Arnold Bruner*

WANT to take your secretary to a night club but think your wife might object?

Trying to choose between two girls—one who looks like Sophia Loren but has a father on relief, the other who looks like the back of a bus but is the daughter of a tycoon?

Like to buy a sporty red convertible but figure you'll get a better trade-in value with a blue sedan?

According to Australian psychiatrist Dr. John Charters Kerridge, these conflicts in day-to-day living turn us into neurotics. But, says Dr. Kerridge, people who have nervous breakdowns are not necessarily inferior.

"They may indeed be some of the finest and most valuable people," he said. "Their problem is mental conflict which arises when instinct urges an action, but experience suggests that the consequences may be undesirable." He outlined four ways to handle conflicts and remain on a more or less even keel.

Sublimation: An overly-aggressive man can become a fighter for a good cause. A student with an abundance of sexual drive may throw all his energies into sport.

Projection: Shift of guilt or failure to someone else. A bad workman decides his boss has it in for him. A cranky alcoholic blames the jitteriness of his children on TV.

Overcompensation: A man proves he doesn't really have any undesirable urges by going the other way. "The reformed rake becomes a strict moralist. The man who doubts his sexual ability becomes a Don Juan."

Displacement: Something like sublimation. Instead of attacking the thing that's bothering him, a person transfers his hostility

The above article originally appeared in the September 17, 1965 edition of The Toronto Star. Mr. Bruner is a Star staff writer.

ity to something else. Sometimes this can be disruptive in a business office. Dr. Kerridge gave the example of a Sydney businessman who was nagged constantly by his wife. He would yell at his secretary. She would abuse the accountant. He would take it out on the typists, and they would turn on the office boy. Since there was no one for him to yell at, he would kick the office cat.

Things got so bad the firm hired an efficiency expert who soon got to the bottom of the problem. Now when the boss's wife nags him, he strides into the office and slashes through all the red tape by immediately kicking the cat himself. ■

Dilemma for Drug Addicts — U.S. Version

*by Hon. John M. Murtagh**

“**A**LCOHOL is the cause of all crime.” A New York City judge made this pronouncement almost a century ago. He referred to the fact that in the 1870's more than half of that city's arrests were for drunkenness. Most of those arrested were hapless immigrants seeking escape in drink from the heartaches of utter misery.

It would be just as easy to point to narcotics as the cause of all crime in New York today. Day in, day out, scores of addicts appear in the Criminal Court, charged with the sale or possession of small quantities of drugs, or with unlawful entry, shoplifting, petty larceny or prostitution—crimes they committed to support a craving for drugs. They, too, are mostly new arrivals in the city. But to explain crime by narcotics is as superficial as blaming it all on alcohol.

Our questionable approach to the “problem of excessive

* Judge Murtagh's article originally appeared in *AMERICA*, May 25, 1963 and subsequently in *The Municipal Court Review*, Vol. 5, No. 2, August, 1965. Judge Murtagh is Administrative Judge, Criminal Courts of the City of New York.

drinking" is centuries old; our policy toward drug addiction is relatively new. For many years there was virtually no Federal legislation on narcotics. But in the course of time, various individuals and groups became increasingly alarmed about drug addiction. In response to their demand that "something be done about it," Congress in 1914 passed the Harrison Act. To this day, the Act is the cornerstone of Federal and State legislation with respect to narcotic drugs.

Properly interpreted, the Harrison Act is a sound law. It is not a prohibitory statute. It is more in the nature of a regulatory act: by using the taxing power, Congress sought to control the distribution of drugs. Even those who are most critical of society's attempts to solve every social and moral problem by passing a criminal statute have no special concern about regulatory legislation.

Why, then, is there criticism of our national policy with regard to drug addiction? The answer is that, although Congress intended the Harrison Act to be regulatory, the Federal government does not administer the law in that spirit. The Treasury Department applies the Act as if it were criminal or prohibitory in nature. And bureaucratic policy can be much more important than the intention of the legislature in determining the manner in which a law is enforced.

By 1920, the public opinion that inspired the passage of the Harrison Act had become more vocal. Exaggerated and disturbing reports about drug addiction were circulated. A committee with official status even reported that there were a million addicts in the United States—an estimate that now seems to have been preposterous.

The medical profession, too, played a part in developing public opinion about drug addiction. The leading members of the American Medical Association became more and more concerned about a relatively few doctors who were exploiting the weakness of addicts. These physicians had virtually abandoned the practice of medicine and were taking advantage of their license to practice in order to become criminal drug peddlers.

Some AMA leaders urged vigorous action by the authorities.

Through their efforts, the Treasury Department was persuaded to seek from the courts an interpretation of the Harrison Act which would forbid doctors to administer drugs in the course of therapy for addiction. The U.S. Supreme Court in three successive decisions—though only by a divided vote—gave considerable support to the interpretation urged by the AMA and the Treasury Department.

In 1925, however, another case, involving the criminal conviction of Dr. Charles O. Linder, came before the Supreme Court. The court by this time realized that it had taken the wrong tack and expressly stated that its prior rulings were to be confined to the facts then before the court. It unanimously reversed Dr. Linder's conviction. "The Harrison Act," said the court, "says nothing of addicts and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for medical treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purpose solely because he has dispensed to one of them, in the ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction."

But the Linder case has had no influence on official policy. In its earlier decisions, the Supreme Court had given considerable support to the Treasury Department's way of administering the Harrison Act. By 1925, the Treasury had literally terrorized doctors away from the treatment of addicts. The court's decision gave little encouragement to medical practitioners to resume the treatment of addicts, since the government ignored the Linder decision and continued to administer the law in accordance with the prior rulings. The Treasury Department asserts its own policy in regard to the use of drugs to this day.

Under the government's policy, a doctor who administers drugs to an addict faces the possibility of indictment and prosecution with all of the humiliation and expense involved in criminal litigation. And, of course, he may also go to jail. So, regardless of what the law of the land may intend, government

policy continues effectively to limit doctors in the practice of medicine when the patient is a drug addict.

A Pathological Problem

Drug addiction is a pathological problem. The addict not only uses drugs, he has a pathological craving for them. So overpowering is this desire that it largely or entirely overrides his free will. Ordinarily, the addict is going to get his drugs regardless of the obstacles, law or no law.

Addiction is not only pathological in itself, it is also symptomatic of a much more deep-seated and complex pathology. It is a reflection of the fact that the individual is emotionally and socially disturbed. The medical problem which the addict presents is that of both addiction and the underlying emotional condition which causes addiction.

Were an addict free to visit his private physician, the doctor's first responsibility would be to determine why the patient was addicted. If the addict were subject at that moment to a craving for drugs or to withdrawal symptoms, he would not be in a state in which the doctor could establish rapport with him. Before the doctor could begin his therapy, he would have to create a greater degree of tranquility in the patient. Whether or not he should administer a limited quantity of drugs would be a medical question, not a question for either the lawyer or organized society.

Prior to 1920, if an addict sought medical help a doctor would have felt free to consider his individual problem. Since that time, however, the Federal government has taken the attitude that the doctor deals with an addict at his peril. That is so, at least, if his medical judgment indicates to any degree that there should be temporary or prolonged administration of drugs. As a result, the medical profession has withdrawn from the care of addicts. No longer can an addict present his complex problem to the medical practitioner. He must seek his solace and relief elsewhere.

This was the situation that began to confront the addict in the 1920's, when the criminal element in society was growing

wealthy as a result of our hypocrisy in a related field, the sale of liquor. Organized crime quickly saw that despite the risks inherent in smuggling, the profits from the sale of narcotics would be large. We, the people, were presenting the criminals with a hard core of addicts, persons who simply had to get their drugs from one source or another. We had stopped the legal source and consequently, once organized crime engaged in smuggling, these persons were their customers.

Worse than this, the underworld soon found that the pathetic addict often could not refuse to become a dope pusher in order to meet the new blackmarket prices for his own needs. The real narcotics racketeer found that he ran a relatively small risk of detection, since it was the addict pushers and the small fry who would be arrested.

Thus began the phenomenon, in a city like New York, of an annually increasing number of arrests. Last year, for example, the arrests for possession of narcotics amounted to some 7,000—virtually all of the defendants being people who were slaves to drug addiction.

One naturally asks: Is there hope for the drug addict? Assuming that he wants to be cured, can he obtain help? Are there individual doctors who will diagnose and treat him? Are there outpatient clinics to which he can go? Are there institutions that offer a cure?

Doctors Abandon The Addict

In the main, the answers are in the negative. Since 1920, doctors have all but deserted the addict. The outpatient clinics which existed in 1920 were all closed shortly thereafter. Some observers ascribe the closing of the clinics to the impossibility of treating addicts effectively except in closed institutions; others blame it on the maladministration of the early clinics; still others point to the government's attitude. Whatever the cause, there are virtually no such clinics today. Nor are there any closed institutions or hospitals that pretend to be able to cure the addict.

But what of the Federal institutions at Lexington, Ky., and Fort Worth, Tex., or New York City's Riverside Hospital? These institutions have been providing humane and medically supervised detoxification of narcotic addicts and have been trying to develop a cure. But they have had little or no success so far. In fact, Riverside Hospital, after more than ten years of experimenting with the treatment of thousands of young addicts, has just been closed.

Recently, the City and State of New York have provided many additional institutions for the care and treatment of addicts. In appropriate cases, addicts are permitted to "volunteer" for civil commitment in lieu of criminal prosecution. This policy is in some respects commendable. But it must be pointed out that the work which these institutions are doing is largely experimental. Those in authority do not pretend to have a cure at this time.

From an objective standpoint, at least, the use of narcotics may well be a violation of the moral law. In addition, since addiction is to a greater or lesser degree contagious, the use of narcotics has an impact on the common good of society. But experience plainly shows that the attempt to legislate addiction out of existence is generally futile. Besides, the enforcement program has done much to sustain organized crime and creates occasions for the corruption of enforcement officers. Our present policy, therefore, is of questionable value.

Perhaps nowhere is the cruelty of the policy more evident than in the Criminal Court of New York City. As many as fourscore addicts confront a judge of that court in a single day. In his heart, the judge knows that there is little or no hope for any of them, yet he must go through the motions of supporting an enforcement program which, he is convinced, is creating more serious problems than it solves.

Addiction is a condition of human degradation. It cries out for humane tolerance and Christlike charity. But these unfortunately, are not the qualities that we now bring to the problem of addiction. The time has come to reassess our approach to the problem. ■

A.R.F. Extends Hamilton Service

THE Hamilton branch of the Alcoholism and Drug Addiction Research Foundation, which opened in 1958 as an information centre, recently expanded into a 20-room suite occupying almost all the second floor of the Undermount building in downtown Hamilton. It includes rooms ranging from a comfortable lounge to pharmacy.

The official opening on October 20 began with a tour of the centre, conducted by



Left to right: Mrs. Ann Townsend, Junior League volunteer, Dr. G. H. Ettlinger, H. David Archibald, A. Ideson, Dr. C. L. Bates, T. A. Rice, and Dr. H. T. Ewart.



Mrs. Wendy Murray, Junior League volunteer, greets guests on arrival at the new Hamilton centre.

members of the Hamilton Junior League, who are volunteer workers at the Foundation. The Rev. T. R. Davies, minister of Runnymede United Church, Toronto and a former chairman of the Hamilton branch Board of Trustees, officiated at the dedication service. H. David Archibald, provincial executive director, presented a portrait of the late Dr. E. M. Jellinek — a world authority on alcoholism — to T. J. McKenna, Q.C., chairman of the Hamilton Board of Trustees.

The highlight of the opening was the announcement by The Honourable Matthew B. Dymond, M.D., Ontario Minister of Health, that a 50-bed hospital for alcoholics will be opened in Hamilton, probably by the end of next year. The hospital will be created by converting and adding a wing to the West Pavilion, near Chedoke General and Children's Hospital on the Hamilton Health Association grounds. It will be the property of the HHA, but its clinical aspects will be directed by the Alcoholism and Drug Addiction Research Foundation.

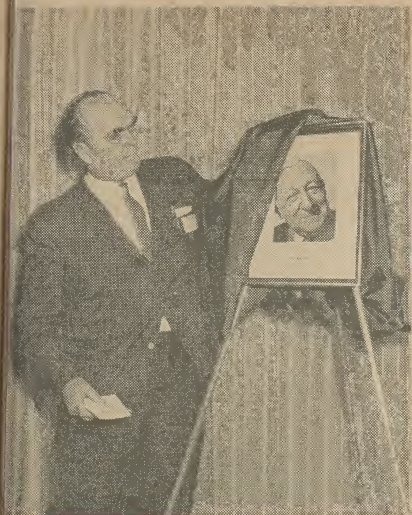


S. R. Stevens of Toronto, Chairman of the Foundation.

Testimonial scrolls were presented to 15 distinguished guests including: Mrs. Ada Pritchard, M.L.A., Mr. Justice W. D. Parker, Q.C., Mr. Beamer W. Hopkins, Q.C., the Rev. Dr. T. R. Davies, B.D., Mr. J. S. Foley, Mr. R. J. Sazio, Mr. D. F. Hassel, His Honour Judge H. C. Arrell, Dr. J. W. Tice, Dr. C. L. Bates, Dr. C. G. Beacock, Dr. J. C. Hall, Dr. W. R. Webster, Dr. W. J. Charters and Dr. Mary E. Purdy.



Foreground: Dr. Mary E. Purdy receives scroll from Mr. Archibald, Executive Director
Background: T. J. McKenna, Q.C., Chairman of the Hamilton Board of Trustees.



H. David Archibald unveils a
memorial portrait of the late
Dr. E. M. Jellinek.



The Honourable Matthew B.
Dymond, M.D., Minister of
Health for Ontario.

“Roads to Maturity” Can Help Prevent Alcohol and Drug Dependency Problems

By Robert R. Robinson

AN experience of potential significance to the prevention of alcohol and drug abuse problems in Canada took place November 1-4 in Montreal. It was the Second Canadian Conference on Children; and it involved some 400 men and women in the health, welfare, and education professions from coast to coast. The conference theme was “Roads to Maturity”—and many people have characterized alcohol and drug dependency problems as flourishing in immature personalities and in an immature society.

The conference was unique in several important respects, among them in its emphasis upon small group discussion. A minimum of time was spent listening to speakers offering formal addresses (7½ hours), and a maximum (13½ hours) was invested in face-to-face exchange among people of differing geographical, cultural, and professional backgrounds but sharing a common concern—the wellbeing of young people and their development to full potential. Maturity was demonstrated by the conference planners in venturing such a break with tradition; and it paid off handsomely. Those attending did not long remain mere members of an audience: they became involved.

Another break with conference ritual of the past was the absence of formal resolutions or recommendations. Instead, a “conclusions committee” derived the sense of the three days of small group discussions through an ingenious listening-in system, and wound up with a simple statement of principles believed to be important in helping Canadian young people to achieve maturity. Dr. J. F. McCreary, Dean of Medicine, University of British Columbia, served as chairman of the conclusions committee and set forth the following principles as the meeting—but not the thinking—ended:

1. Any problem which impedes progress to maturity cannot be solved by any one professional group alone.

2. This being true, it follows that in the training for each profession there must be included a component which involves inter-professional collaboration and experience.
 - Health is not solely the problem for the physician
 - Education is not only the terrain of professional teachers.
3. It follows also that the significant number of professionals in many communities should increase their cumulative impact on the problems of children by forming multi-disciplinary working groups.
4. It will be necessary to use much greater imagination in finding ways of creating a more effective deployment of professional personnel such as doctors in rural areas.
5. It will not be possible to prepare sufficient professionals to meet the needs of children in the future and it is probably a more desirable alternative to share some of the functions now performed by professionals among other individuals.
6. Under these circumstances, it becomes the duty of professionally trained individuals and the policy makers to analyze community needs and methods of utilizing semi-professional and non-professional individuals with appropriate preparation. Any new training program should develop through the collaboration of universities, community colleges, technical institutes, extension departments and community agencies.
7. The volunteer should play a much greater role in the provision of services to children in the future than in the past. If we are to develop sufficient numbers of volunteers much more imaginative approaches must be made in attracting, preparing and using them. With the acceleration of automation a vast new reservoir of personnel becomes available whose expanded non-working time could well be spent in volunteer services.
8. We are very concerned with the inequality of educational opportunity among Canadian children and we are equally concerned that conditioning forces within the home and

the environment limit the ability of some children to profit from normal educational opportunities.

9. We believe that any parent or guardian whose child is refused an educational opportunity by a local school board, for any reason, must have access to a neutral tribunal for review.
10. We support the stand of teacher-training colleges that the present duration of training is in most instances inadequate to provide all the skills and understandings which teachers must possess.
11. Canada's effort in basic and applied research into the social sciences has been pitifully small. It is urgent that both financial support for such studies and opportunities for preparation of research personnel be made available. In this connection we welcome the indication that the Vanier Institute on the Family will substantially support such research.
12. A positive and open-minded approach is urgently needed if we are to join with young adults to meet the challenges which they face. ■

5th ANNUAL SUMMER COURSE
on
ALCOHOL AND PROBLEMS OF ADDICTION

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Course Director,
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221 Elizabeth Street,
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A.I.T. Addictions

3 SCL. MED. DIV.

SPRING, 1966

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Hamilton—143 James Street South (525-1250)

London—477 Waterloo Street (433-3171)

Ottawa—1206 Bank Street (733-8343)

Sault Ste. Marie—674 Pine Street (256-2226)

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A.I.T. Addictions

SPRING, 1966

WE seem to know little about the causes and effects of the use of hemp products — marihuana, hashish and the like — despite the fact that the drug in one form or another has been used in many parts of the world for many centuries. Its use in North America is a novelty compared to its use on other continents, but still it has been with us for several decades: the legendary boat that carried jazz up the river from New Orleans apparently carried marihuana as well.

Yet a scientific consensus on the use of hemp has been slow in forming, and one can hardly say that it has entirely jelled as yet. Elsewhere in this issue Dr. Murphy remarks that much of the existing literature is "quite confused," and that even the most recent literature is "not really enlightening." There is not even agreement on the spelling of North America's most popular hemp product: should it be marihuana or marijuana? A case can be made out for either, and our own choice is largely arbitrary.

The chief centre of marihuana use in Ontario is undoubtedly Toronto, and there is reason to believe that its use in Toronto increased markedly during 1965. Reliable estimates of prevalence are hard to come by, but it is suggestive that police statistics show 68 arrests on charges involving marihuana in Toronto last year, as compared with an average of about 17 and a max-

imum of 32 in the preceding seven years.

Arrests indicate the existence of a social problem; and the existence of a social problem involving the use of a chemical constitutes a reason for concern on the part of this Foundation. Early last December magistrates began referring marihuana users to the Foundation in the expectation that we might be able to find a solution to the problem. When clinical assessments of marihuana users begin to be brought together with results of work in which our research division has been engaged for some months, a solution may begin to appear.

We are indebted to Dr. Murphy for allowing us to reprint his survey of the literature, which was first published in 1963, and also for volunteering to bring it up to date for us.

We are also indebted to Dr. Bell for his general review of chemical comforts, which may remind us that although marihuana appears to be the most newsworthy of the problem drugs in Ontario at the moment, other drugs that have been with us in this province much longer continue to cause far more widespread and far more serious problems.

Our chief problem chemical is still ethyl alcohol, and we are fortunate to be able to reprint Mr. Aharan's talk on the causes of alcoholism, which was much appreciated by those who attended our summer school last year. — A. McC.

Librarians: this issue is Volume 13, Number 1 (not Volume 12, Number 4). In future, the four issues for one calendar year will constitute one volume.

The Cannabis Habit

A review of recent psychiatric literature

by H. B. M. Murphy, M.D., Ph.D.

During a recent visit to the island of Jamaica to plan some socio-psychiatric research, it was pointed out to me that medical men there were in need of guidance and possibly research on the question of cannabis habituation. Neither local psychiatrists nor general practitioners were clear regarding which disorders should be attributed to the drug, and it was hoped that I could provide some answers. As the following review shows, however, the Jamaicans are by no means alone in the confusion which they feel on the subject, and further research seems called for.

The present notes cover the majority of scientific papers published on cannabis over the past twenty-five years and referring to the psychiatric sequelae to its use. I have chosen to ignore most of the literature dealing with purely botanical, biochemical and physiological aspects of the subject, as also most papers from a psychiatric or pseudo-psychiatric viewpoint which did not appear to be based on original observations.

Varieties, preparations and active principles of *cannabis sativa*

Cannabis sativa, *cannabis indica* and *cannabis americana* are agreed to be the same plant, varying somewhat in size and appearance with climate and soil, but always producing an intoxicating principle.^{2 34} It is consumed in many ways and under many names in different parts of the world — hashish, kif (N. Africa); ganja, charas, bhang (India); ma jen (China); dagga (S. Africa); marihuana or marijuana (N. America); maconha (S. America). Conditions of cultivation probably influence the strength of the active principle,^{13 57} but less so

Dr. Murphy is an associate professor in the department of psychiatry at McGill University, Montreal. This paper first appeared in the United Nations Bulletin on Narcotics, Vol. XV, No. 1, January-March, 1963. It is reprinted here with the permission of Dr. Murphy and the U.N.

than the conditions of collection and preparation. The main psychopharmacological agent, tetrahydrocannabinol, has been reliably identified^{2 14 25} and appears to be produced mainly or exclusively by the unpollinated female flowers. Preparations from the leaves of the plant contain little or none of this agent, whereas those from the pure resin excreted by the flowers at a certain period contain it most strongly.^{2 8} Ganja, marihuana and most other commonly used preparations usually consist of the chopped, dried flowers and tops, but there is considerable variation in the manner of preparation. Smoking with deep inhalation appears to produce more rapid and more predictable results than ingestion,^{3 12} but the latter is also used, and a snuff is sometimes found.

A synthetic analogue (synhexyl) was at one time used for the treatment of depression^{2 35} but proved less satisfactory than later antidepressants.

The drug can be fractionated and identified by paper chromatography, which should contribute to a more rapid understanding of its elements, but there is as yet no satisfactory test for its detection within the body.^{14 29}

Short-term psychological effects

Many reports exist of cannabis being given to volunteer subjects—both naive and experienced in its use—and there is considerable unanimity regarding the initial effects. These are: (a) a dulling of attention; (b) loquacious euphoria of variable duration; (c) usually some psychomotor activity * and affective lability * coloured by the underlying personality; (d) perhaps some distortion of perception and time sense, depending on the dose; (e) perhaps some lassitude culminating in deep sleep if the dose is sufficient.^{2 3 8 9 12 46 51} In South Africa, the staff of the Pretoria mental hospital distinguished three categories of reaction:—cases showing dullness and fatuous euphoria only; cases showing additional irritability and mild excitement, culminating in sleep; and cases showing additional confusion.³¹ A summary of the re-

*Psychomotor activity: restlessness and excessive movement; affective lability: emotional instability.

action of 100 *regular* users to a single dose, as reported by the Chopras from India, is given in the accompanying table. Other

TABLE I

Summary of reactions of 100 subjects accustomed to cannabis smoking, after administration of $\frac{1}{2}$ g to 2 g of ganja or charas through a pipe

<i>Effects</i>	<i>Number</i>
1. Euphoria and feeling of exhilaration	74
2. Depression	12
3. Increased energy, desire and capacity for work	39
4. More talkative	60
5. Mental activity and efficiency increased	30
6. Mental activity and efficiency decreased	10
7. Sharpening of appetite	58
8. Diminution of appetite	30
9. Appetite not affected	12
10. Feeling of constriction in the throat	40
11. Reaction to work as regards fatigue:	
(a) Less fatigue	60
(b) Sense of fatigue enhanced	20
(c) No effect	20

effects, produced in some subjects only, are an oneiric ecstasy,*
⁸ ¹⁰ ³⁶ an acute sensitivity to sights and sounds, especially any
slight noise; ⁸ ⁹ hallucinations and delusions; ⁹ anxiety; ⁹ and de-
pression. Most observers agree that the experienced user can be
distinguished from the novice by his knowledge of the correct
dose required to produce the euphoria (or oneiric ecstasy, if that
is the aim) without any of the more disturbing effects, and it is
also found that most habitual users regulate their intake in this
way. ³ ³¹ ⁵¹

Intellectually, the drug appears to be able to release repressed
ideas, but at the same time reduces work drive so that the ideas
are rarely followed through or put into action. Thus, Rorschach

*An ecstasy resembling a waking dream; the word comes from the Greek *oneiros*,
a dream.

tests carried out under the drug showed greater originality and elaboration in the responses, with greater variety, but at the same time the number of responses was reduced.⁵¹ Mechanical tests under the drug resulted in greater speed, but at the same time loss of accuracy.⁵¹ A naive subject of Adams, when under the drug, more than held his own at poker against expert players, thus showing that mental acuity was not reduced when attention was held, but painter and musician subjects of Williams, left to themselves, failed to carry out the creative programme they had mapped for that time. Performance in I.Q. tests appears to be either slightly reduced⁵¹ or unchanged.⁴⁶

Antisocial behaviour

Aggressiveness or antisocial behaviour is agreed to be less common with cannabis than with alcohol,^{3 12 20 46} but there are three main types of situation in which it can arise. The first is when a naive subject develops a panic state in response to the hallucinatory experiences which the drug induces, and in his panic attacks any object in sight.⁹ The second is during the phase of hypersensitivity and psychomotor activity when the subject's reactions to unpleasant external stimuli may be more emphatic than is customary.³ The third is when the drug is taken, as alcohol might be, to release repressed feelings of hostility. Bouquet has stated that the drug is still sometimes used in North Africa by criminals seeking confidence before a sortie⁸—the use among the original Assassins—and Charen notes that relief from inferiority feelings can lead to bullying, swashbuckling behaviour. He states that although his negro soldier habitues were delinquent without the drug, they were more so when under its influence.¹¹ However, there is no doubt that such uses, or such events, are exceptional. Most serious observers agree that cannabis does not, *per se*, induce aggressive or criminal activities, and that the reduction of work drive leads to a negative correlation with criminality rather than a positive one.^{3 9 12 41 46}

In the papers reviewed, the only instances where cannabis is alleged to have led to homicide or mayhem in such a fashion

refer to North Africa and are not well documented;^{7 8} but the suggested effects are plausible and hence should be kept in mind for their medico-legal significance.

A further qualifying point that must be kept in mind is that the results of taking cannabis are considerably influenced by the individual's expectations or by the social or cultural setting. In the North American negro subjects of Charen and of Marcovitz some sexual stimulation and release of repression was expected and much sexual activity resulted, although most investigators are agreed that cannabis has no aphrodisiac effect. In Indian Brahmins and some N. African groups a form of oneiric ecstasy is quite regularly obtained^{7 10 12} whereas in South African and North American subjects it is rarely mentioned.^{11 20 28 31 46} The hallucinations and disturbances of time sense sought and reported by the "Club des Haschischins" of Baudelaire and Gautier are avoided by most users elsewhere.

Addiction

There is at the present time a recognized discrepancy between the medical and the legal definition of addiction, and the discrepancy is nowhere more confusing than in the case of cannabis. In 1955 the WHO Expert Committee on Addiction-producing Drugs stated that "cannabis itself comes definitely under the terms of its definition of addiction."^{15a} Two years later, however, they found it necessary to emphasize the difference between addiction and habituation, and when such a distinction is made the question arises whether cannabis ought to come under the heading of habit-forming rather than addiction-producing. Since the distinction between habituation and addiction was an attempt at increased scientific precision rather than a legal dictum, however, the declaration against cannabis has never been changed, and the question has not been publicly discussed by the Committee.

Addiction, according to the 1957 Expert Committee, is characterized by:

- "(1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;

- “(2) A tendency to increase the dose;
- “(3) A psychic (psychological) and generally a physical dependence on the effects of the drug; and
- “(4) A detrimental effect on the individual and on society.”¹⁵

Habituation, according to the same report, is distinguished by absence of true compulsion, absence of physical dependence, little tendency to increase the dose, and by use of the drug only for the pleasurable sensations it induces, not for relief of feelings of lack. The obvious illustration of a habit-producing drug is alcohol.

“Habit-forming”

The majority of papers here reviewed hold fairly clearly that, in terms of the above definitions, cannabis is “habit-forming” rather than “addiction-producing”. Most individual users intensively studied could accept or abandon the habit without withdrawal symptoms; none of them showed true physical dependence; none of them had shown a real tendency to increase dosage and most, when given as much as they asked for, tended to be quite moderate in their demands or to reduce dosage.

In North America, the main recent data supporting a belief in an addiction-producing effect relate to two groups^{11 28} of mainly negro soldiers who either demanded to be given the drug or sought army discharge on the grounds that they were useless without it. One has a strong impression, on reading the two papers, that these subjects were playing strongly on the nuisance value of their alleged addiction, and Charen notes that “when talked to in a kindly, sympathetic manner, feelings of anxiety which they attributed to the drug deprivation disappeared in the course of the interview because they were able to represent themselves as adequate individuals in terms of their own standards.”

¹¹ This is not the reaction one would expect from true addicts, and the over-all picture might be interpreted rather as attachment to what we now call a delinquent subculture—one in which marihuana smoking plays a limited but significant role—than as a dependency on the drug itself. Nevertheless, the general failure of the Marcovitz or of the Charen team to wean the

subjects away from their demands for the drug does suggest an addiction to something, even if it be only a way of life which the marihuana supports, and even if the subjects were poor material in the first place.

Not "addiction-producing"

All other main investigators within the United States deny an addiction-producing effect. Allentuck *et al* state that "the psychic habituation to marihuana is not as strong as to tobacco or alcohol."³ Freedman & Rockmore, studying a much larger sample of army habitues than the Charen or Marcovitz teams, could find no evidence of deteriorating effect on mind or on body, and noted that most of the users had gone without the drug for long periods without reduction in efficiency or need for medical help.²⁰ Two official army pre-war investigations, published a little more than 25 years ago but deserving mention since they appear to have been overlooked by other reviewers, concluded that "there is no evidence that marihuana as grown here (Panama Canal Zone) is a habit-forming drug in the sense in which the term is applied to alcohol, opium, cocaine, etc.," and that "no recommendations for further legislative action to prevent the sale or use of marihuana are deemed advisable."⁴⁶ Finally, the New York Mayor's committee on the subject in the 1940s, having given it the most careful study it has received anywhere, concluded that it was neither a significant addiction-producer itself, nor a serious channel to other addictions.³⁰

In contrasting these North American opinions it should be remembered that the subjects of the Marcovitz and Charen teams would be inclined to paint a bad picture of their dependency on cannabis, in the hope of receiving army discharge or of escaping punishment, whereas the subjects of the other investigators might be inclined to paint an over-favourable impression in the hope that cannabis might become more easily available.

Elsewhere in the world there is a similar contrast of apparent innocuousness for the average intermittent or light user with something like real addiction in a minority. For Morocco, for instance, Benabud states that in country districts "cannabis addic-

tion shows no signs of being a compulsive need" but that it is a "mass addiction among the urban proletariat." ⁷ In South Africa "many natives apparently use drugs as the European uses alcohol" and on the same analogy "it is only over-indulgence in drugs which produces the marked mental symptoms." ³¹ In India some of the subjects in the Chopras' survey took quite limited doses, found themselves unharmed by it, and could stop when they wanted to, but others, mainly those taking larger doses, felt themselves harmed and yet could not stop. This possible association with the dose or type of drug used is also brought out by North African writers, where hashish is stated to be eight times as strong as kif or ganja, and much more likely to produce addiction. ^{8 36} However, it does not appear that it is the availability of the stronger preparation alone which makes for addiction. In Lebanon, where much hashish for the illegal Egyptian market is reported to be produced, fewer than five addicts a year are admitted to the main Asfuriyeh mental hospital, although one would expect that popular ideas regarding its innocuousness would lead to many users. ²³

All this does not suggest that the drug by itself induces dependency and addiction in its subject. However, it does offer an escape from the world, and for individuals whose personal inadequacy or social misery are great enough the desire for such escape may lead to a rejection of life without the drug, which is indistinguishable from addiction. ²⁵ And, for the present, cannabis definitely remains a proscribed drug in terms of the WHO Expert Committee's statements and under the laws of many countries.

Long-term psychological effects

As with alcoholism, it is quite difficult to distinguish the longer-term effects of cannabis use from the personality traits or changes which would have been present whether the drug had been used or not. Where the drug is regularly taken, and in considerable quantity, the main characteristic is sloth or lethargy. The stereotype of the habitue in North Africa is the man sitting day-long at his doorstep with his pipe. There are no

data to show whether these characteristics are reversible, but Chopra implies that the determination of the chronic smoker is so weakened that natural reversal of the effect after withdrawal of the drug is unlikely. "The psychological treatment, training and education of the addict is as important in the case of cannabis smokers as in opium addicts, in spite of the fact that the physical distress accompanying withdrawal is largely absent."

^{12b} But where consumption is less, or more irregular, evidence of chronic mental deterioration is difficult to obtain. The 310 users reported on by Freedman and Rockmore had an *average* history of 7.1 years use, and yet showed no evidence of mental or physical deterioration.²⁰ The 67 criminal offenders who were discovered by Bromberg to have been former users showed no characteristics that could be attributed to the drug, although, as might be expected in any criminal population, they did show some psychopathy and a low average I.Q.⁹ In the army Panama Canal Zone investigation there had apparently been complaints by unit commanders about delinquency or unsoldierly conduct on the part of some users, but the medical commission, after a year's study, thought that these qualities could be adequately accounted for by the fact that "a large proportion of the delinquents are morons or psychopaths" independently of their taking the drug.⁴⁶

Main concomitants

When the drug is consumed regularly in considerable amounts, the main concomitants reported by the Chopras are: insomnia or reduction in normal sleeping time; minor impairments of judgment and memory; limited self-neglect; and on the somatic side much chronic bronchitis, some asthma, pharyngitis and disturbances of the large bowel.¹² To these must be added, at least as a possibility, the disturbing psychotic and pre-psychotic states noted below.

Incidentally, the Chopras noted that although injection of the transverse ciliary vessels* is an important sign of ganja use,

*A type of bloodshot eye.

it remains present for years after the drug has been withheld, and thus is no indicator of *recent* use.¹²

Cannabis psychosis

Most investigators covered in the present review warn that it is exceedingly difficult to distinguish a psychosis due to cannabis from other acute or chronic psychoses, and several suggest that cannabis is the relatively unimportant precipitating agent only. Thus, Allentuck states that "a characteristic cannabis psychosis does not exist. Marihuana will not produce a psychosis *de nova* in a well integrated, stable person."³ Reales Orozco *et al* report six cases only doubtfully distinguishable from schizophrenia, alcoholism, etc.⁴⁰ The Pretoria investigation noted that "in most of the cases who were diagnosed as dagga psychoses on admission, alcohol has also played its part in producing the mental derangement."³¹ Bromberg calls for more precision in making the diagnosis, using such criteria as "disordered sensorium-ed, * characteristic coloured visual hallucinations, time changes;"⁹ but one finds that among the 21 cases of psychosis involving cannabis which he discusses in his paper, seven were clearly functional psychoses merely precipitated by the drug, seven presented as acute toxic psychoses but got readmitted to mental hospital within two years with a diagnosis of schizophrenia, and one presenting with a similar picture was readmitted with a manic-depressive psychosis. Even with stricter criteria, therefore, the nature of the psychosis remains in doubt. Benabud appears more confident about the diagnosis being made by his psychiatric colleagues in Morocco, and since they have a much greater experience of such conditions than North American psychiatrists this confidence may not be unjustified. However, the clinical data which he presents are unclear, and it is not easy to infer from his paper just what characteristics or patterns are taken as distinguishing a cannabis psychosis from the acute toxic states associated with malnutrition and endemic infection.⁷ Porot suggests that in North Africa some cannabis psychoses

*Perceptions.

are mislabelled dementia precox, for despite an early and apparently grave onset, some patients with this picture unexpectedly recover.³⁶ However, such acute schizophrenic episodes are found elsewhere in the world, without cannabis being involved, and it is not clear whether the patients referred to are always proven cannabis users, or only assumed to be such.

In old habitues, several writers have reported a chronic dementia with apparently rather characteristic episodes.^{5 8 21} The main claims for this are from North Africa, where Aubin claims the evolutionary pattern to be quite characteristic.⁵ Frazer has reported nine rather different cases from a relatively small number of Indian Army units,¹⁹ and Gaskill found one possible case in an American negro soldier.²¹ In Frazer's cases the men were recognized by their comrades to be untrustworthy, and were apparently rather shunned. Experiencing some deprivation of the drug, they became irritable, showed an outburst of violence, a latent period of apparent normality, and a second outburst of violence followed by acute psychosis if the first warning was not heeded. The symptoms during the psychotic episode were quite similar to those of certain alcoholic psychoses, with terrifying hallucinations, a craving for the drug and filthy or violent behaviour. All the patients recovered within weeks or months, thus differing from the North African cases.¹⁹

Incidence of psychosis

With the diagnosis normally so much in doubt, it is easy to understand that estimates of incidence or prevalence are difficult. The Chopras found nine cases of frank insanity in 466 cannabis smokers and four cases in 772 cannabis drinkers, yielding "active prevalence" rates of 1.93 per cent and 0.52 per cent, respectively.¹² Such rates are not much different from the "active prevalence" rates for total psychoses obtained in different community surveys in Europe and North America, rates which range from 0.6 per cent to 2.1 per cent of adult populations. Benabud estimates "recurrent mental derangement" in Moroccan users at 0.5 per cent.⁷ The U.S. Army Panama Canal Zone investigation yielded no report of a psychosis arising over a one-

year period from what might be estimated to be 500 users.⁴⁶ Freedman and Rockmore obtained no history of mental hospitalization from their 310 subjects, even though these averaged 7.1 years of usage.²⁰ Bromberg found no psychosis in the 67 criminal offender users he specifically investigated, and appears to imply that he noticed none in the several hundred other criminal offender users whom he had routinely interviewed.⁹ Bouquet for Tunisia states that "victims scarcely ever attain a condition of dementia; it is not in the mental asylums that they are to be found but in the riff-raff of professional beggars, vagabonds and thieves."⁸ For Algeria, Porot would appear to agree.³⁶ Only in Allentuck's sample is the proportion of cases with a history of psychosis high (nine out of 77), but that has little meaning since he located them through hospitals and institutions.³

The data just cited all refer to any form of psychosis, not to specific cannabis psychoses. Hence, we have the paradox that although it is well established that cannabis use attracts the mentally unstable (see, for instance, the Chopras' finding cited below) the prevalence of *major* mental disorder among cannabis users appears to be little, if any, higher than that in the general population. Admittedly such data may contain some fallacies, but the techniques used by the Chopras in studying their habits differed very little from those used in more modern mental health surveys. Therefore, it would appear that true cannabis psychosis must either be very rare indeed, or that it must be substituting for other forms of psychosis. Also, the data raise the question whether the use of cannabis may not be protecting some individuals from a psychosis.

Personality traits of cannabis users

Becker has pointed out that since cannabis, unlike heroin or cocaine, develops no physical dependence, initiation and an available supply of the drug are not sufficient to lead to habituation. For the initiate, who does not know the dose that would best suit him, first experiences are usually either disappointing or unpleasant and quite frightening. For him to persist, there-

fore, he must usually have (a) encouragement to persist through trials until the intended experience is obtained; (b) encouragement to regard the resultant sensations as pleasurable; (c) secondary advantages such as a sense of membership of a marihuana-using sub-culture; (d) lack of satisfactory contact with disapproving social attitudes or agents; and (e) lack of competing sources of pleasurable experience that escape cannabis's disadvantages. ^{6a} ^{6b}

Isolated user rare

For these reasons, the isolated user, in contrast to the secret alcohol drinker or morphine addict, is rare, and use tends to be associated with membership of some section of society rather than with individual personality traits. Thus, in some parts of India Brahmins may use cannabis, but high caste Kshatriya (warrior castes) usually do not. ¹⁰ ¹² In Morocco cannabis is especially the resort of the underprivileged new urban proletariat, ⁷ but in East and South Africa, although cannabis (dagga) is known, the new urban proletariat turns to alcohol. ³¹ In the United States, where society in general is hostile to cannabis, the user is normally a member of some half-extruded minority group, ¹¹ ²⁸ but in Mexico, where public opinion is tolerant, it is reported to be used by the normal majority. ⁴⁹ Findings concerning the personality traits of users in one society will not, therefore, necessarily be relevant for other cultures, and in particular the personality traits of North American users are unlikely to be applicable to users in more tolerant lands.

Nevertheless, there are certain characteristics which distinguish the *heavy* consumer of cannabis, irrespective of culture. Thus, in North Africa, India and in the United States heavy cannabis consumption is almost exclusively male, and predominantly for the under thirty-five age group. ⁷ ¹¹ ¹² (The latter observation may be partly an artefact derived from the nature of the various investigators' sources, but at least it would seem that the older habitue draws less attention to himself.) In the three territories, again, the heavy user appears to be especially the man in a marginal economic position, cut off from satisfac-

tory family ties and lacking stable residential roots.^{7 11 12} One of the striking things about the Morocco survey was the fact that 30 per cent of patients had changed their residence more than twice within a year.⁷ Since the habit is both a convivial and a male affair, it is natural that it should attract homosexuals,^{8 11} and since it tends to produce lethargy or inaction it can be understood to appeal more to the man who seeks to escape from his frustrations than to the man who seeks to break through them. The latter, if he uses cannabis, will customarily combine it with alcohol, but most cannabis habitues avoid alcohol, finding that it spoils the particular sensation which they are seeking.^{9 51}

Because of its hallucinogenic properties, a subgroup of users to be found in most countries is those who seek its aid for religious or semi-religious inspiration. In Africa there was actually a cult insisting on cannabis use,⁵³ and African minority cults in the New World also appear to use or tolerate it. In Brazil, for instance, one of the proposed measures of control of the drug habit was the registration of Afro-Brazilian societies¹³ and in Jamaica the Ras Tafari movement and cannabis use have been linked. In India, it is alleged that excessive use of the drug, as opposed to moderate use, is especially to be found in religious mendicants seeking to give an impression of supernatural influence to a credulous public.¹² In North Africa, fakirs may use it similarly, but apparently the true adepts tend to be more moderate in their use.³⁶

Neurotic histories

Neurotic or psychopathic histories are found in many cannabis users, and the Chopras show clearly that where a stronger and a weaker preparation of cannabis are available, subjects with a neurotic history chose the stronger, whereas other subjects tend to choose the weaker.¹² However, whereas in North America the main prior disorders reported tend to be of an antisocial or psychopathic character, in India it is claimed that cannabis users are timid, rarely antisocial in a violent way, and much less of a trouble to their communities than habitual drunkards.^{11 12}

Carstairs contrasts the alcohol consumption of the warrior castes in India with the cannabis consumption of the Brahmin,¹⁰ and Benabud suggests that whereas alcohol suits the European's aggressiveness and dynamism, cannabis suits the Moroccan's mixture of resignation, exaltation and impulsiveness.⁷

Other effects

Since this is a psychiatric review it is not intended to cover studies of the other pharmaceutical properties of cannabis except to ask what light, if any, they shed on the centuries-old folk-belief in its medical virtues. The WHO Expert Committee on Addiction-producing Drugs has reaffirmed¹⁶ its opinion that cannabis does not deserve to remain on the pharmacopoeia, since it has no medicinal effect which outweighs its disadvantages or which cannot be substituted for; but this is not to say that the drug has no medicinal properties other than that of intoxication. In fact, the literature of the past decade makes quite frequent mention of other possible effects.

The most interesting of these is an antibiotic effect, recently quite actively investigated in Eastern Europe.^{32 38 39 44 54 55 56 57} It is alleged to be active against a wide range of organisms at 1/100,000 dilution, but to be largely inactivated by plasma, so that prospects for its use appear to be confined to ear, nose, throat and skin infections. If such an effect were possessed by the crude preparations, it would explain some of the traditional belief in the drug. Two other effects which are also likely to have contributed to the belief and which beyond question reside in the crude preparations are a diuretic effect and an increasing of appetite. The diuretic effect has been described and explored by Chopra and by Ames.^{4 12} The effect appears to be cumulative, to last about 12 hours on a single dose, to be unaccompanied by any abnormality in the urine composition, and to result in the excretion rising to over 2,000 ml per diem.¹² The stimulation of appetite has been described by many experimenters in the U.S.A.,^{4 51} and is so well known in India that it is incorporated into proverbs warning that the poor man should not take cannabis lest he eat up his food reserves.¹²

As a not unnatural consequence, it has been found that the occasional user looks healthy and well fed, although the habitual user does not.

Less credibly, the drug has apparently been used in China for the treatment of appendicitis.²⁶

Pathological somatic sequelae are apparently rare or poorly explored. The bronchitis of chronic Indian smokers¹² is presumably due to the crude smoked material as much as to the specific drugs, but the throat complaints of the same subjects may be a specific result. The Chopras do not believe that it causes asthma, although a number of users have asthma¹² and may have taken cannabis for relief. Porot cites Clérambault as stating that chronic users may develop a penetrating ulcer on the sole,³⁶ and, perhaps as an associated phenomenon, an arteritis has been reported recently from the drug.⁵⁸ The lethal dose (for Indian ganja) is about 8 g per kg body weight, whereas the daily consumption of heavy users is rarely above 10 g per adult, so that there remains a wide latitude between customary use and lethal dose.¹²

As a combined tonic, diuretic, antibiotic, sedative and pain reliever, then, cannabis appears to have merited its place in folk-lore and in the older pharmacopoeias, with little risk of poisoning or of somatic sequelae. Today it may be true that none of these effects is of sufficient strength and reliability to justify the drug's retention by modern medicine; but at least one can understand why, considering its extreme cheapness, it is still valued by the poor in many countries.

Conclusions

From the above review it is clear that there is still much to be learnt about the effect of cannabis on the human mind. In compiling this review, I have naturally had to stress majority opinions or majority findings, and hence I have probably made the picture more straightforward than it actually is. One meets, in such reading, not only conflicts of opinion, but apparently conflicts regarding observations, and it seems probable that cannabis has a highly complex influence, dependent on person-

ality and culture as well as on the drug itself. Several of the writers draw attention to our continuing ignorance, and call for better investigations in a society where users are neither facing special problems of adjustment (e.g., adjustment to army life) nor suffering public and legal censure. There is still a need for a properly designed study into the frequency of symptoms at different levels of consumption, such as can be done only by community survey under conditions of unrestricted communication between subject and investigator. The Chopras' investigation most closely approaches what is required, and the wealth of information presented is most admirable; but it is not clear how they obtained their subjects or whether their sample was representative. One has the impression that it was weighted on the side of the heavy user.

Closer to alcohol

Both in the complexity of its effects and in more specific characteristics, cannabis is much closer to alcohol than to the opiates or to cocaine. Like alcohol, it appears to have no deleterious effect on the moderate user, who knows the correct amount for obtaining relaxation or euphoria without additional effects. As with alcohol, single doses given to naive, unstable subjects can produce an acute confusion, perhaps with violence, while the long-term use of heavy doses can probably lead to partial dementia or to an organic reaction type psychosis. Like alcohol, it is alleged to carry no danger for the stable personality, but to attract the neurotic and psychopathic, who are also the people that tend to take the heavy doses. Neither drug has a significant tendency to produce physical dependence; neither drug leads to withdrawal symptoms under normal conditions; and in neither case does desired dosage tend to increase with time. Finally, where the drugs are not prohibited, society's attitude towards the deteriorated chronic user is in both instances one of great tolerance.

There are differences, of course. Cannabis in large doses may be more poisonous, and in small doses it has a more distorting effect on certain mental functions. It is less liable to lead

to aggressiveness and antisocial behaviour, but more likely to lead to an asocial passivity. It has a greater variety of medicinal actions than alcohol, and fewer pathological sequelae within the body have been reported, though perhaps only because alcohol has been the more studied.

Why cannabis is banned

In this light it is clear that the free availability of cannabis can be harmful, but it is not so clear that this is more harmful than the free availability of alcohol. The question, arises, therefore, why cannabis is so regularly banned in countries where alcohol is permitted. One reason may be that, having little direct experience with the drug and hearing the alarming picture reported from countries such as Egypt, these other countries have decided simply to be on the safe side. Another reason may be that the causes of cannabis habituation are confused with its effects. A third reason may be that, because few other pleasures are available to a mass of the people in certain countries, recourse to cannabis there follows the disastrous pattern of the recourse to alcohol in eighteenth-century Britain. One cannot read Benabud's sympathetic description of the Moroccan urban proletariat without realizing that life offers such people very few inducements not to drown themselves in a cannabis illusion. However, there is yet another reason why, I think, alcohol is tolerated in Anglo-Saxon countries while cannabis is feared. It derives from the work ethic of Protestantism and its hostility towards inaction. In India, cannabis can be tolerated and even used by the Brahmin priesthood because social inaction can have a positive connotation, whereas alcohol, with its potential release of repressed impulses, is disapproved of as a disturber and distracter. In Anglo-Saxon cultures inaction is looked down on and often feared, whereas over-activity, aided by alcohol or independently of alcohol, is considerably tolerated despite the social disturbance produced. It may be that we can ban cannabis simply because the people who use it, or would do so, carry little weight in social matters and are relatively easy to control, whereas the alcohol user often carries plenty of weight in social matters and

is difficult to control, as the U.S. prohibition era showed. It has yet to be shown, however, that the one is more socially or personally disruptive than the other.

Summary

The psychiatric literature on cannabis smoking over the past 25 years is quite confused as regards the effects attributed to the drug. However, majority opinion appears to be that cannabis is habit-forming, like alcohol, and not addiction-producing, like opium. It probably produces a specific psychosis, but this must be quite rare, since the prevalence of psychosis in cannabis users is only doubtfully higher than the prevalence in general populations. More important is the mental inertia and lethargy which its use can produce, leading heavy long-time users to resemble chronic deteriorated alcoholics, though with less aggressiveness. Single doses in correct amount produce euphoria, but in greater amount may produce hallucinations or distortion of perception, with hypersensitivity and emotional lability.

The medical reputation which cannabis has in folk-medicine appears to have some justification since, although erratic in action, it possesses a number of valuable properties.

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* The papers of Benabud ¹ and of Roland and Teste ⁴² are largely reproducing one another and it is not clear whose opinions they represent. For simplicity, only Benabud has been referred to here.

Addendum: 1963-1965

In the three years since the above was first published, articles on cannabis habituation have become more common but not really more enlightening. There is still debate on whether the drug can cause psychosis, with Moraes Andrade from Rio de Janeiro holding that it does not,⁸ and Asuni from Lagos² and Pires da Viegua from Bahia⁹ suggesting that it does but not providing any method whereby such psychosis can be distinguished from other acute schizophreniform states. Both in West Africa and in New York it is noted that it is especially marginal individuals who use cannabis, but whether such people would have any better lives without it is unclear and there tends to be more emphasis than formerly on the need for social reconstruction if we are to be justified in prohibiting the habit.^{6 9} However, there is still also the general feeling that the drug should be restricted, if for no other reason than that public access to any drug that affects mental functioning is undesirable,¹ a remark which is recognized to apply to alcohol and caffeine as well. The more traditional arguments for prohibition, namely that the cannabis habit leads to more dangerous addictions and that its disinhibiting effect can release criminal tendencies, still carry much weight,^{1 2 6 9} but are challenged by two experienced investigators.

The first of these is Laurretta Bender. Bringing to the subject the careful observation of juvenile and adolescent patients for which she is renowned, she writes that marihuana "only occasionally is followed by heroin usage, probably in those who would have become heroin addicts as readily without the marihuana."³ For her, the drug is relatively unimportant as a factor in mental disorder and criminality in New York's adolescents; and she reminds us that in Sweden, where cannabis was not known, a slimming drug acquired the same role in the teenage culture.¹⁰

The second is Moraes Andrade. Analyzing the psychiatric findings on 120 individuals referred by the courts for examination on suspicion of having committed a crime while under the

influence of the drug, he found no evidence that criminal or dangerous actions were taking place under the drug that would not have occurred without it.⁸ Thirty-seven of the 120 were of normal mentality, merely trafficking in the drug; 42 showed evidence of psychopathic behaviour regardless of whether they were taking the drug or not; the remainder had some form of mental disorder, usually schizophrenia, which similarly exhibited itself at other times.

For the rest, the components of this complex substance are becoming better understood, but not fully disentangled.⁴ A useful distinction has been made between those that are present before smoking (and presumably available by ingestion, as in traditional medicines) and those that survive into the smoke.⁷ From India, a plea has been made that the drug remain available in the villages to the Ayurvedic practitioners at least until the latter are trained to use modern drugs, since it is important in so many traditional remedies.⁵ In West Africa, on the other hand, it was not indigenous or a component of traditional remedies so that there is no real obstacle to prohibiting its cultivation and some sound reasons for attempting this.⁶—H.B.M.M.

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Summer Course

A distinguished Finnish sociologist who is an international authority on alcohol problems will be among the experts contributing to the Foundation's fifth annual summer course at the University of Waterloo this June. He is Professor Heikki Waris, head of the Institute of Social Policy at the University of Helsinki, chairman of the executive board of the Finnish Foundation on Alcohol Studies and a member of the United Nations Research Institute for Social Development.

Professor Waris will take part in many formal and informal discussions during the two-week course and will give two formal papers: "Alcohol, Drugs and Society—A World View" and "Social Management of Addiction."

The course is a concentrated survey providing basic information to those who, in their professional work, are called upon to deal with problems related to the abuse of beverage alcohol and other drugs. Attendance is limited to 80 persons. Admissions are controlled to ensure balanced representation from medicine, nursing, social work, education, law, the Church, and business and industry.

More than 300 members of the helping professions in Ontario have taken part in previous courses given at the University of Toronto, Queen's University, the University of Western Ontario and in Ottawa with the co-operation of Carleton University and the University of Ottawa.

This summer's course at Waterloo will be sponsored jointly by the university's Faculty of Engineering and the Department of Psychology. It opens June 5 and closes June 17. Admissions will close very shortly after this issue of ADDICTIONS reaches its readers—application forms must be mailed no later than April 8. Prospective applicants should write to: Course Director, Addiction Research Foundation, 221 Elizabeth Street, Toronto 5, or telephone 365-4585, area code 416. The admissions committee will notify all applicants before May 12.

Chemical Comforts

by R. Gordon Bell, M.D.

The variety of things that are happily swallowed, inhaled or injected continues to increase as the chemical route to adventure, comfort and a trouble-free life becomes more popular. The health aspects of this trend can only be considered in a very general way in a brief article of this kind; the social, political, economic, legal and moral implications can merely be mentioned.

With all of the liquids, solids and gases that can somehow enter the human body, one basic rule always applies — there is a limit to the quantity that can be safely absorbed. Danger is determined by three factors: the relative danger of the substance, the amount taken over a given time, and the resistance of the individual.

These factors affect the direct or unlearned responses to any stimulus from the environment — physical, bacterial, chemical or other — and in most areas have led to successful programs to improve health and extend life expectancy. Purification of water, milk and food has markedly reduced the quantity of bacteria encountered in civilized countries, while resistance has been increased by vaccination and strongly reinforced when necessary by antibiotics. The net result has been a marked increase in life expectancy during the last century. In industrial situations involving chemical hazards, the amount to which employees are exposed is being kept below dangerous limits more and more effectively.

Desire and dose

In dangerous quantities most gases, liquids and solids produce unpleasant effects. Under these circumstances awareness of danger can be an effective deterrent. A bewildering variety of

Dr. Bell is the executive director of the Donwood Foundation, Toronto, and a member of the professional advisory board of this Foundation. This article first appeared in the book, *The Decisive Years*, published in 1965 by Barker Publishing Co., a division of The Townley Publishing Co. Ltd., Toronto. It is reprinted here with the permission of Dr. Bell and the publishers.

substances are also available that can produce pleasurable effects in both safe and dangerous quantities. A desire to eat, drink, smoke, or use drugs may be either safe or dangerous, according to the particular effects desired and the amounts required to produce them. The stronger the desire, the more difficult it is to control, the bigger dose, and the greater the risk of physical, mental and social damage.

The enjoyment of any substance is determined by the characteristics of both substance and consumer. Gases, liquids and solids become desirable prior to and during intake through their appeal to the senses and thereafter by their capacity to alter the way people feel. One brand of American beer is currently advertised as appealing to all the senses — including the sense of sound. When a beer becomes melodious as well as flavorful, fragrant, attractive and smooth, the ultimate in sensory appeal has been attained.

Enjoyment following ingestion is usually due to a speed-up or slow-down effect on the nervous system. For example, the discomfort of anxiety, frustration or pain can be temporarily relieved by the depressant action of alcohol, sedatives, tranquilizers or narcotics; the discomfort of depression by stimulants like caffeine or dexedrine. These are examples of *negative* enjoyment — from distress towards normal. Many stimulants and depressants can produce *positive* enjoyment in certain people from normal towards ecstasy or euphoria. Enjoyment of food is due to the effect on the body generally rather than on any particular system.

Initial desire

The consumer must have the physical and mental characteristics to experience welcome effects from harmful quantities, and be in a social setting that can maintain an abundant supply. Some people are fortunately content with the effects of safe quantities of food, tobacco, alcohol or drugs and are able to restrict their desire to the intake of these quantities without any conscious effort. Since they are not overwhelmed by their appetites, they can reap the rewards of moderate indulgence as

long as they live. In others, the desire for a comforting substance can grow out of control and eventually begin to crowd other desires out of existence.

Accordingly, some enjoy getting *high* while others simply get sick. Many an unwary drinker has lived to curse the natural tolerance that denied early awareness of dangerous intake. The ability to get high without discomfort, or to drink more than most without getting drunk, also indicates an individual tolerance which will produce similar reactions to the anesthetics, sedatives or other depressants to which cross-tolerance with alcohol occurs.

Similarly, some can enjoy more food than they need, while others become uncomfortable when they eat too much. Thus, the physical state can be as important as emotional distress or social pressure in initiating desire for excessive quantities of food, alcohol, tobacco or drugs. However, social pressure or emotional need may maintain experimentation with dangerous quantities in spite of initial discomfort in some people until adequate tolerance is acquired.

The mental state that encourages a harmful dependence on chemicals is a sustained desire or willingness for change. Relief from distress, pursuit of pleasure or a wish to belong can all contribute to the sustained desire. Some only nurture one unhealthy appetite — for food, tobacco or alcohol. The present trend is to multiple abuse of comforting chemicals with increasingly complex repercussions.

Origin of desire

Desire may originate in pain, anxiety, frustration, depression, boredom, loneliness or other distress. The majority of those who are introduced to drugs by occupation or medical treatment plus a goodly percentage who seek self-solace in food, alcohol and tobacco, have a sustained desire for change of this type.

An interest in chemical adventures for *kicks*, to rebel, or simply to improve a distress-free norm — as exemplified by drinking to *feel good*, rather than to relieve distress — can also sustain an unhealthy desire. This route to chemical disaster is

made easier by unquestioned adherence to dangerous drinking customs.

If welcome effects from chemicals are balanced by welcome reactions to people the danger of overdependence on chemicals is reduced. Perhaps the most important psychological factor encouraging pleasure from things is a difficulty or an inability to enjoy the world of people. Rejection and brutality in childhood, over-protection, over-indulgence, over-discipline, inconsistent parental attitudes or parental disharmony can produce mental scars that erect barriers to communication. These may be reinforced by influence from the community, if, for instance, a puritanical *taboo against tenderness* prevails to throttle spontaneous expression of affection and reduce the rewards from interpersonal contact. More difficulties in communication can be encountered as an adult by virtue of occupation, marital status or community acceptance, to reduce still further the rewards from the world of people. When human solutions to loneliness and trouble are impossible, chemical solutions may seem the only hope.

Reinforcement of childhood pleasure is another psychological factor in chemical enjoyment. Eating, drinking and *smoking* are also pleasurable in infancy. When infantile delights are perpetuated and reinforced by adult approval and acceptance, the basis for strong desire is assured.

Four-fold appeal

Thus the initial desire may result from a four-fold attraction — to the senses, to the action on the nervous system or other parts of the body, to the renewal of pleasurable activities, to the awareness of conforming or to any combination. The initial desire for tobacco involves all four; it appeals to the sense of taste and smell, it has an acceptably mild stimulating effect on the human nervous system, it renews the soothing activity of thumb-sucking and initiates participation in a very popular communal activity. Under these circumstances, awareness of danger has little deterrent effect.

The eaters — the users of food — make up the largest fellow-

hip for self-indulgence. Some restrict their eating to the satisfaction of physical need; others, tempted by the alluring sight, taste and smell of food, committed to self-solace by unfulfilled emotional needs, and surrounded by an abundant supply, join the fraternity who resolve their immediate difficulties by the first method that worked — relaxing with a full stomach. As with smoking and other abnormal desires, awareness of dangers is often less compelling than the desire to eat.

The initial desire for alcoholic beverages is also due to a four-fold appeal. Tradition and social custom encourage initiation into an exciting adult fraternity — taste and smell are reassuring, effects may be intensely rewarding, while swallowing a comforting liquid is a pleasurable activity of long standing.

Drugs, on the other hand, have fewer components to their welcome effect. The renewal of childhood pleasure is negligible, taste and smell are rarely pleasant and participation in off-hand chemical adventures, while increasing, still attracts a rebellious minority. The initial desire to use drugs is almost entirely due to their ability to speed up or slow down one or more functions of the human nervous system. This brings relief from distress or increase in pleasure, in either case a temporary shift upwards on the pain-pleasure scale.

Society and desire

The social situation affects growth of desire through control of supply. A desire to indulge in the excessive use of anything cannot be fulfilled unless sufficient quantities are available. In prosperous times most people have enough money to purchase repeatedly more alcohol, food, tobacco or drugs than can be used safely. When this is balanced by adequate supply, the tragedies of abundance occur.

Three social situations initiate and sustain most of the potentially threatening human-chemical relationships. Occupation can foster an unhealthy use of food by the housewife, chef or food-handlers, and a comparable problem with drugs by physicians, nurses and other members of the clinical professions. Medical treatment can initiate dependence on a great variety of drugs

that alleviate distress. The most important and least controllable of the three is social custom. The accepted practice of coming together for the common enjoyment of food, caffeine, alcohol and tobacco, is so deeply rooted in our culture as to be almost impregnable to threat or awareness of danger.

If, by some miracle, everyone should suddenly restrict the intake of all pleasurable products to safe limits, the whole economy would undergo an historic readjustment. There is no need to worry about such a development. If our social habits are ever affected significantly by awareness of danger, the change will come about gradually. Political fortune, government revenue, agricultural markets and vested interest are but a few of the social forces to be affected by such an evolution.

Acquired desire and loss of control

Whereas one set of physical, mental and social factors accounts for the initial capacity to enjoy too much, additional factors are responsible for the ability to continue doing so — the capacity for adaptation to the repeated intake of too much.

Warmed by pleasant effects both during and after intake, by the renewal of fond associations and by an awareness of belonging, many who become acquainted with a pleasurable substance proceed to fall in love with it. The initial complex dependence on its capacity to improve the way they feel expands still more as the physical and mental changes of adaptation to excess occur. The first reasons for an unhealthy dependence are usually not strong enough by themselves to make desire uncontrollable. Although compelled to use harmful quantities repeatedly to achieve a desired effect, the ability to stop when necessary is retained. The process of adaptation gradually produces the insidious self-perpetuating changes that increase desire and reduce control. Gradually day-to-day existence is molded around the activities that maintain supply. As one patient put it — “an unhealthy desire became a compelling need.”

The ability to adapt, physically and mentally, to excessive quantities of anything facilitates development of dependence and postpones awareness of danger. This ability varies widely and

may be partly determined by inherited factors. For example, obesity — an indication of capacity to adapt to excessive quantities of food — may occur in all members of a family. The rapidity with which the additional self-perpetuating mental and physical desires from adaptation occur varies greatly from substance to substance as well as from person to person, as does the power of the total desire to control the life of the victim. An acquired self-perpetuating desire for tobacco or narcotics on the average occurs much more quickly than a similar desire for alcohol and in a much higher percentage of users.

Mental adaptation or habit produces a need to repeat a pleasurable activity for its own sake. The original conditions for chemical enjoyment expand to include more and more day-to-day activities. Often the initial reasons for using something are quickly replaced by others. This is particularly marked with tobacco — smoking for the sake of smoking replaces smoking to belong to the gang, and in the process becomes a compelling, self-perpetuating activity; "*force of habit*" is a very apt phrase.

"Craving"

Simultaneously, physical adaptation to dangerous quantities produces another compelling self-perpetuating component to desire. An increasing need for regular intake becomes necessary to maintain a new, abnormal state of internal balance. Otherwise the abnormal state of balance is disturbed and the distress of withdrawal experienced. The body signal for more of the substance to maintain abnormal equilibrium and so avoid or relieve withdrawal discomfort is usually referred to as "craving". It is helpful to differentiate craving — a signal to maintain an abnormal state — from hunger and thirst, which perpetuate normal functions.

The state of the body during withdrawal is the opposite to that produced by the drug — e.g., morphine constricts the pupils, which are dilated during withdrawal; alcohol, sedatives, and tranquilizers slow down one or more functions of the nervous system, which are over-active to the point of tremor, hallucinations, convulsions or delirium on withdrawal; caffeine, nicotine,

dexedrine and cocaine stimulate the nervous system which is markedly depressed on withdrawal, and so on.

When the acquired need for physical and mental adaptation is added to the original desire, a powerful complex force controls more and more of the behavior of the victim. Dangerous quantities of alcohol, food, drugs and tobacco continue to be used in spite of awareness of progressive trouble. Whenever a person is trapped in such a conflicting situation he is put on the defensive. Defensive thinking and resistance to treatment become integral parts of the total disability. The defensive thinking is characterized by alibis, lying, cover-up, projection, resentment, suspicion, remorse, moodiness, frustration and a progressive disturbance in communication with others. When mental resources become increasingly involved in defending a sick desire, they are less and less available for attention to socially constructive activities.

Acquired tolerance and habit — the physical and psychological components of adaptation — are accompanied by social adaptation or manipulation. As need for anything increases, other interests and activities must be modified to accommodate the need. The worker who is forced to give prime attention to his abnormal need for alcohol finds a special use for the coffee-break, lunch, the business meeting in the next block, walking the dog, tending bar or visiting a sick friend — to mention but a few of the daily activities that acquire new, compelling purpose. Manipulation breaks down more rapidly when a substance like alcohol, sedatives or tranquilizers is involved which can alter behavior in a sociably undesirable manner, or when its use is illegal, which is the case with the narcotic drugs. With a compulsion to smoke or eat neither obstacle to manipulation prevails and the victim can usually manipulate his home, work, and community life to accommodate his abnormal desire until he happily dies of lung cancer or heart failure.

Consequence of uncontrolled desire

Whenever desire leads to the repeated intake of dangerous quantities, physical damage eventually develops. Excessive smok

ing hurts the parts of the body concerned with breathing and circulation; heavy drinking — the nervous system and the digestive system — over-eating, the circulatory and weight bearing structures, and so on. The main threat from tobacco lies in the fact that the majority of smokers soon acquire a self-perpetuating desire for dangerous quantities, whereas the majority of drinkers do not. To balance the threat, uncontrollable desires for tobacco or food threaten the user only — the health and life-expectancy of others is not involved. An uncontrollable need for alcohol or sedatives not only affects the victim but all others with whom he is closely associated. In fact the social consequences in the home, on the job and in the community are the most noticeable features of the whole disability. As deterioration of physical health and social relationships continues, guilt, remorse and despair further complicate the mental state of the victim. If desire remains uncontrollable, and consequences unbearable, suicide frequently provides the only solution.

Hints for health

Many of the new tranquilizers and stimulants are particularly dangerous. The careless, unsupervised use of these products by college students has already led to widespread needless tragedy. Danger may be immediate — either from fatal over-dose of depressants, or from using stimulants until they *whip the tired horse* to the point of exhaustion or death, or from alternately using depressants and stimulants. To accentuate the hazard from repeated use, many of these products lead to a surprisingly rapid development of uncontrollable need. Any student with the slightest regard for health and life expectancy should use all drugs under strict medical supervision.

The argument that the new drugs have become an essential part of adjustment to twentieth century reality is based on misconceptions covering both hazards involved and the latent resources of the average person. When the new mood-changers are used along with the old-timer, alcohol, the possibility of chemical disaster increases.

As we gradually shift our attention from the physical, mental

and social consequences of abnormal desire to the inactivation of desire itself, new hope for recovery from the primary disability occurs. Instead of concentrating on obesity — one of the more obvious consequences of an unhealthy desire for food — the practice of repeated dieting is replaced by an attempt to correct the tension, loneliness or boredom initiating a sustained desire to over-eat. Instead of concentrating our clinical and legal attention on the physical and social consequences of an uncontrollable desire to drink, the components of this desire could be identified and progressively inactivated. Instead of remaining so excited about the consequences of an abnormal desire for narcotics, we might better concentrate on the physical, psychological and social situations that initiate it, and the unique power of the acquired desires that reinforce it.

The unprecedented developments in the world of chemicals of the past few decades have produced a host of new products for medical, cosmetic, industrial or other use. Many of them can produce pleasant effects in harmful quantities — glue for model planes, nail-polish remover, perfume, and a bewildering assortment of new drugs, to mention a few. To meet the new threats to health and safety that will become increasingly apparent in the last part of this century, new techniques in health education will have to be developed. Perhaps the widespread rebellion against adult patterns of behavior will expand to include rejection of their smoking, eating, drinking and drug habits.

True awareness

No amount of warning about consequences will succeed unless the desire to improve the way we feel by swallowing, inhaling or injecting is reduced. Chemicals replace people in the lives of many. It is just possible that age-old humanitarian goals are nearer attainment than ever before. As the social sciences continue to confirm the human need to love and be loved, is it not possible that they will also provide the techniques to meet this need? A new dimension in understanding and compassion should be possible as true awareness of the nature of man and what is good for him replace the arbitrary moralistic standards.

that contribute to so much tension, loneliness and misery. Perhaps the greatest challenge of the new generation is to contribute to this new dimension in understanding. As the rewards from people increase, interest in chemical comforts should diminish to safer levels.

Protective Drugs

The clinical staff of the Foundation has prepared this information to give to patients for whom protective drugs may be prescribed. It may also be of interest to others who are concerned with alcoholics and their treatment.

What are the protective drugs?

They are drugs that were developed to help you keep from drinking. Their trade names are Antabuse and Temposil.

How do they work?

Your body ordinarily has a good process for getting rid of alcohol. The protective drugs interfere with this process and cause an unpleasant reaction.

What is the reaction like?

If you drink even a small amount of alcohol while you are on a protective drug, you may experience these sensations: flushing, dizziness, sweating, shortness of breath, pounding heart, throbbing head and nausea. If the reaction is severe, you may even collapse and pass out. The more you drink, the worse your reaction will be.

How can a protective drug help me?

Knowing that just one drink will make you sick can strengthen your determination to avoid drinking.

Will the drug alone cure my alcohol problem?

No; it is only a way of helping you to keep off alcohol while you try to gain a better understanding of yourself and your problem through such means as personal interviews, group therapy sessions or Alcoholics Anonymous.

Can I stop taking the drug and go and have a drink?

No; if you have been on Antabuse, there may still be enough in your system to cause a reaction as long as two weeks after you have stopped taking it. In that time, if you really want to keep from drinking, and find that Antabuse helps, you can start to take it again. Temposil gives protection for only one or two days.

Is it dangerous to drink while I am on a protective drug?

Yes; the reaction may be severe. But you will not be given the drug if your physical condition is not satisfactory.

What about medicines that contain alcohol?

You should make sure that any medicines you get from your doctor or pharmacist do not contain alcohol. Many liquid medicines do contain enough alcohol to cause a reaction.

If I have a reaction, what should I do?

Call your doctor, or go to the emergency department of the nearest general hospital and show your special identification card.

What is the card for?

The card warns doctors not to give you any medicines that contain alcohol. It also tells doctors how to take care of you if you have had a reaction. As long as you are on a protective drug, you should get a new card every three months.

Do I have to take a protective drug?

No; but if you and your doctor agree that a protective drug can help you, he will prescribe one for you.

Where can I obtain them?

They can only be prescribed by a physician. If for any reason you cannot continue as a patient at the Foundation, your own doctor can prescribe the drug for you.

How long do I have to be off alcohol before I can start taking the drug?

The doctor who prescribes the drug for you will decide this. The time varies from a few hours to two days, depending on how much alcohol is in your system.

How do I take the drug?

Both drugs are in the form of tablets which you take once

or twice a day. Your doctor will decide which drug you should take, and in what amount.

Are the drugs dangerous to take?

They are harmless if you take them as prescribed. You may get a few mild side-effects. Sometimes the side effects go away in a few days, sometimes the dose has to be reduced a little. Many people have taken these drugs for years without harmful effects.

How long should I take a protective drug?

You and your doctor must decide that between you. You may take it continuously or intermittently for a long time—perhaps a year or longer. You should not stop taking it without discussing the situation with your doctor.

(Reprints of this article are available without charge to physicians in Ontario.)

Brookside Monographs

The fifth in the Foundation's series of Brookside Monographs, "The Amphetamines—Toxicity and Addiction," will be published in May by the University of Toronto Press. The author is Oriana Josseu Kalant, a physiologist who is a research associate with the Foundation.

Dr. Kalant's report is a comprehensive review of the toxic and addictive properties of amphetamines. Some of the previous literature on these drugs has been interpreted as suggesting that their use does not pose a problem, but Dr. Kalant's report shows that a problem does exist and that, in fact, it is widespread. The problem has also been recognized by the World Health Organization, which recently stated that the abuse of amphetamines is reaching epidemic proportions.

Dr. Oriana Kalant is the wife of Dr. Harold Kalant, who is the Associate Research Director for Biological Studies at the Foundation.

Theories of Causation

By C. H. Aharan, M.A.

In view of the fact that there is still little agreement about what alcoholism is, it is not surprising to find considerable disagreement among the various theories of causation. A growing number of specialists in the field of alcohol studies are concluding that there is no unique disease entity called alcoholism but that there are many alcoholisms, each requiring its own theory of causation. While it is true that there is much disagreement the picture is not entirely black; most theorists agree on two broad basic categories of causal factors: a facilitating culture and a prone individual. The disagreement arises over the nature of cultural facilitation and the nature of individual proneness—and, of course, where the emphasis is to be placed.

The approach a theorist takes in the explanation of causal factors of any event starts with or grows out of his particular orientation. He will, naturally enough, try to make sense out of phenomena within the field of his special competence. The physiologist will look for physiological explanations of human behaviour, the sociologist for social explanations, the psychologist for psychological explanations, etc. How the individual perceives the event to be defined is also related to his particular prejudice. Probably what we do most often is to decide what a behaviour is or means and then set about developing an argument that supports what we have already concluded. The way the theorizing game is played at the present time is to acknowledge at the beginning that alcoholism has a multi-factor causation and then to develop a lopsided theory that emphasizes your own particular bias. I intend to follow the rules of the game in this paper, and the bias I will reflect is that of a clinical psychologist. In order to allay the guilt I feel for presenting a lopsided point of view, I will endeavour to classify existing theories in terms of

Mr. Aharan is director of the Lake Erie region of the Foundation. This talk was given at the Foundation's fourth annual summer course in Ottawa in June, 1965. It is reprinted here with Mr. Aharan's permission.

the degree of emphasis they place on one or more of the common causal factors.

Figure 1 presents a classification of theories in terms of where the major emphasis is placed. The weights given, as represented by the asterisks, are completely arbitrary and you may feel they are not properly distributed—in which case feel free to move, add, or delete signs as you wish. A further qualification should be mentioned: the research that went into the preparation of this paper was minimal and it is entirely possible that important theoretical positions have been omitted and some theoretical positions misrepresented. The purpose of this form of presentation is to demonstrate the basis of theorizing and it is not intended that all of the important theories should be presented in detail.

FIGURE 1

Classification of theories of causation on the basis of emphasis on various factors considered to be of etiological significance

Type of Theory	Physical	Social	Psychological	Spiritual	Alcohol
1	*****	*			
2	***	**			*
3	***	*	*		
4	*	***	**		
5	*	****	*		
6	*	*	****		
7	*	*	**	***	
8					*****

Type 1—The theories included in this type place all the emphasis on physical factors, acknowledging only that cultural factors are necessary in the provision of alcohol and the permission to drink it. Included in this type would be theories such as Williams's Genetotrophic Theory and most theories postulating some type of inherited constitutional predisposition.* Also included in

*Roger Williams's theory postulated an inherited enzyme deficiency.

this type would be those causal explanations that suggest that alcoholism is, or results from, an allergy. This kind of explanation is most popular among members of Alcoholics Anonymous.

Type 2—This type also places the major emphasis on physiological or biochemical factors, claiming that for some reason, as yet unknown, some people have a natural high tolerance for alcohol. These people, when located in a culture that permits or encourages heavy and frequent consumption of alcohol, drift innocently into alcoholism.

Type 3—This type lays greater stress on cultural and psychological factors but attributes to physiological change the major role in the causation of alcoholism. It holds that the practice of heavy drinking over time results in a change in the body tissues which in turn results in a craving being established. This is the basis of the loss-of-control phenomenon which is often mentioned. This is a widely-held viewpoint and is particularly relevant to the Gamma-type alcoholic first described by the late Dr. Jellinek.*

Types 4 and 5—These types emphasize cultural factors with varying degrees of emphasis on physiological and psychological factors. This is the group of theories—and, in my opinion, a most impressive group—promoted primarily by sociologists and cultural anthropologists. This group of theories has a great amount of research evidence to back it up in the form of studies of different cultures by anthropologists and studies within cultures by sociologists on factors such as religion, rural-urban population distribution, economic conditions, etc.

Type 6—This type includes the group of theories that stresses psychological factors. Within this group one finds the psychoanalytic theorists who consider alcoholism to be a symptom of underlying personality problems usually characterized by a fixation at the oral level of development. The more orthodox the analyst, the less emphasis he is likely to place on other factors.

*In his book, *The Disease Concept of Alcoholism*, Dr. E. M. Jellinek distinguished four kinds of alcoholism which he identified as Alpha, Beta, Gamma and Delta. Gamma alcoholism, widely prevalent in North America, is characterized by acquired increased tolerance, alcoholic blackouts, loss of control and withdrawal symptoms.

Of particular and growing importance within this type are the learning theorists who are endeavouring to explain alcoholic behaviour within the framework of modern learning theory.

Type 7—The theories grouped within this category do not have very many supporters. However, in my opinion, theorizing in the spiritual and existential area holds great promise. These theories hold that alcohol is used by the alcoholic as a substitute for God, or as a way of avoiding the problems of existential anxiety.

Type 8—There is no body of systematized theory within this category, or at least not any that demands serious attention today. This category is presented in order to include a fairly large number of people who have had considerable influence in the past. These people hold that alcoholism, and all related problems due to the presence of alcohol in a society, result entirely from alcohol. These are people who hold—often as a matter of faith—that alcohol is the sole cause of alcoholism.

A useful viewpoint

For the remainder of our time, I would like to present a viewpoint I find useful in helping to make sense of the problem of many alcoholics whom I see. It should be understood that what is to follow is not intended to account for all alcoholics everywhere. I do believe, however, that it does account for a significant number of alcoholics who come for help in our society. I should also like to make it clear that the viewpoint about to be presented is not original, but is a collage composed of bits and pieces picked up from many sources and authors whose names I have successfully repressed.

Let me begin by making a general statement about the nature of the type of alcoholism that I feel is most often seen at our public clinics.

Alcoholism is a complex behavioural disorder that develops in an individual who has a recognizable personality problem, the disagreeable effects of which he tries to compensate for or eliminate through reliance on the effects produced by drinking beverage alcohol, and who resides

in a culture that permits the use of alcohol for this purpose. At the initial stages the use of alcohol is symptomatic of the underlying personality disorder. The problem is progressive in nature, however, to the point where the major symptom—the excessive use of alcohol—may overshadow the causal factor and appear to be self-perpetuating. The rate of progression is determined by the intensity of the underlying conflict and the degree of cultural facilitation.

Alcoholism is correctly described as a social disorder, requiring for its development, not only a prone individual, but also a facilitating culture. The lopsided aspect of the theory I am about to outline is reflected in the fact that I am only going to consider psychological proneness. In order to understand psychological proneness it is first necessary to examine those aspects of culture that may facilitate alcoholism.

The drinking climate

It is well known that the nature of an individual's response to some drugs, including alcohol, is influenced by factors other than the chemical reaction that takes place when the drug is ingested. What a given culture teaches an individual about the use of alcohol will influence if, when, where and how he will drink. It will also create an expectation about how he should feel and behave when he drinks. In our society, for many years, the role of alcohol has been confused and uncertain, as can be inferred from the many conflicting laws that have controlled its use. In view of this, it is not surprising that the attitudes and practices of many individuals who drink are somewhat conflicting and uncertain. In our society the individual cannot always be sure about the appropriateness of his drinking behaviour as he moves from one group to another. While there is a considerable amount of confusion as to the appropriateness of drinking in all situations, there is a widely accepted attitude that alcohol is to be used primarily as a means of altering the way a person feels and particularly as a means of reducing the barriers that separate people from one another. It is also true that in our culture, or in important segments of it, there is a wide-

spread acceptance of drinking to the point of some degree of intoxication. Drinking in our society is also associated with manliness and, as a matter of fact, it is defined by law as an adult privilege. This has resulted in the act of drinking becoming a symbol of manliness and sophistication. Because drinking is prohibited to those under the age of 21, which is roughly four years past the time when most people who drink first start to do so, the act of drinking may also be a means of expressing rebellion. This fact also means that initial drinking experiences are very likely to be associated with deception, guilt and thrill-seeking.

In addition to the attitudes and drinking behaviours condoned in a given society, some consideration needs to be given to the effect of the drug alcohol independent of any cultural or psychological factors. Most responsible authorities inform us that alcohol impairs the functioning of the higher centres of the central nervous system—in particular, that part of the brain which controls our higher thought processes and which determines our essential human quality of self-awareness.

The prone individual

Keeping in mind what I have said about the nature of our drinking climate, and considering the kind of effect the drug alcohol has on the human organism, we can now speculate on what kind of individual would find drinking beverage alcohol rewarding to the point where he would be prone to the development of a harmful dependency. It seems to me that drinking alcohol in our society will be particularly rewarding to the kind of person whose awareness of self is characterized by negative judgments as to his own worth. In addition, he should be an individual who strongly resents the dependency these judgments place upon him. This kind of person would find the liberating effect of drinking in our society particularly rewarding.

Before proceeding further, it is necessary for me to make clear a basic assumption that underlies everything that is to follow. The assumption is not specific to alcoholics but amounts to a belief about the nature of man. In essence the assumption

is that man has the ability to determine, or at least significantly influence, what he will become. This is the uniqueness of human nature: the ability of the individual to be aware of, and to be able to participate in, his own fulfillment. To refuse or to be unable to accept this responsibility is to fail to become a man, is the source of most psychopathology, and is certainly the source of real or existential guilt.

This assumption means that at some point in the individual's development he is meant to take over, to influence and to exercise direction on his own becoming. The most important corollary of this position is that man must be willing to be responsible for what he is.

Observations

Let us turn now to the impressions gained from observing the actual condition of many alcoholics. It seems to me that a very large number of the alcoholics whom I have had an opportunity to observe reveal themselves to be individuals with fairly severe personality disorders manifested by a wide range of symptoms, but very often it seems that they share a similar or common core conflict. Most of the alcoholics I have known seem to be afflicted with a deeply-rooted sense of unworthiness and a fragile or non-existent sense of independent identity which prevents them from making a consistent and vital commitment to life. As would be expected, there is an absence of a strong and personalized system of values and also there is a deficit in willpower which results in an inability to act consistently in accordance with any system of belief. One other feature should be mentioned: the only dedication that many alcoholics seem to possess is to the notion that the good life is a "pain-free existence now". In short, it seems to me that most of the alcoholics I see suffer from a disordered character.

I have introduced the concept "character" and since I do not use it in the same manner as it is most often used in diagnostic systems of classification, it is necessary for me to specify what I mean by the term.

First of all, I do not think of character and personality as

being synonymous, although I am inclined to think of character as a salient, or perhaps *the* salient, feature of personality. Briefly, I think of character as a highly personal system of values and the will to behave consistently in accordance with this value system. Putting it another way, character is belief translating itself into action. The strength of character is the degree to which it determines the individual's choices in situations where the belief system is called into relevance. The individual who possesses a strong character uses his own value system as a reference point in passing judgment on himself. Knowing what one believes and what one is trying to do is of tremendous value in providing for that individual a sense of identity. Whatever else the character may be, it is certainly an integrative process which results in a sense of separate identity, enabling the individual to live with a greater degree of independence and predictability as to the nature of his future being.

“Bad” and “weak” characters

I suggest there are two major categories of character disorder. One is the “bad character” and the other is the “weak character”. The observable behaviours and consequences resulting from these two aspects of character disorder may at times be similar, but the subjective experiences of the sufferers are quite different. The individual possessing a strong but “bad” character does not experience the crippling dread of inner emptiness and the fear of non-being. This person has a recognizable belief system and the will to act accordingly. His problem results from conflict with society. His beliefs and his resultant behaviour are unacceptable to society, but completely acceptable to himself. The defects of a “weak” character may be further subdivided into two groups: those problems associated with defects in conscience, and those associated with defects in will. In most cases, however, there is a defect in the conscience and in the will. The individual with a “weak” character also suffers conflict in his inter-personal relationships, but of far greater consequence is his intra-personal conflict. It is this area of character disorder that I believe is of great relevance to many alcoholics.

Because of some combination of circumstances in his early life, the potential alcoholic was not encouraged to become a person in his own right. His early experiences conspired to teach him that his worth as an individual was always dependent on his ability to be pleasing to the significant other individuals with whom he had to interact. In order to be pleasing he learned that he had to be able to live up to the standards set for him by other people. If these standards were too high and arbitrary and inconsistent, and if failure to meet them resulted in hostility or the withdrawal of love, or both, the individual began to feel that he was not "good enough". As a child he was taught that he was bad; and being bad, he quickly learned, resulted in many unpleasant consequences. It may very well be that he did not really understand what being bad was; however, because he was in the position of being unable to appeal the sentence placed on him, he had to accept this basic fact of his existence, namely, that he was bad or not "good enough". Since it was painful to be bad and since he could not help being bad, he began to feel that the only thing left for him to do was to pretend to be good.

Chronic ambivalence

This is the beginning of the sense of unworthiness I mentioned earlier and also the beginning of a characteristic mode of behaviour which manifests itself dramatically in later years. The individual also learns that independent action is always dangerous and he has little confidence in his ability to make the right choices. Because of this kind of experience, the individual is reluctant to accept the responsibility of participating in the shaping of his own destiny. His conscience is either poorly formed or always external. It is never in him, it is always a policeman on the corner. It is always a fence hemming him in, it is rarely a sign pointing him the way. He resents his dependency, but he fears independent action. As a result, he is in a chronic state of ambivalence. He oscillates between a desire for extreme independence and a need for complete dependence and quite often he demands both simultaneously, which amounts to a desire for freedom without responsibility and dependence with-

out restriction. The rules this person feels he must live by are always somebody else's rules and he longs for emancipation. But the alternative to living by somebody else's rules is terrifying because he either has no rules of his own or no confidence in his ability to stick to whatever rules he does have. In any case, he has no confidence in his ability to run his life and while he resents being told what to be and how to be, he doesn't know what to be or how to be unless he *is* told.

Needs constant approval

This person's sense of well-being is dependent on his receiving constant and unquestioning approval from all others. Real or imagined disapproval is perceived as a threat to his very existence and cannot be tolerated. But although this individual is driven to seek constant approval, he can never be satisfied with any approval he gets. This is because he feels basically unworthy; he cannot see himself as a person who is likeable; thus he finds it extremely difficult to have faith in whatever demonstrations of approval he receives. He may interpret approval by other people as a gesture on their part to manipulate him and get what they want from him. On the other hand, he may feel that he has deceived them—that they do not know what he is really like: in this case, his dilemma is continued: now he will feel that if he moves any closer to people they will get to know what he is really like, and once they see what he is really like they will not like him and will reject him.

This person does not act on his beliefs unless they are accepted and approved by others. He feels that he must constantly shift his opinions to conform to those of the significant others with whom he is interacting. (The other side of this same coin is a persistent opposition to the opinions of others, combined with an unwillingness to accept the logical consequences of such opposition.) Consequently, if this person asks himself, "What will I be tomorrow", or "How will I behave tonight?" he cannot give an answer; these are questions with large elements of uncertainty for him.

Alcohol is a highly effective drug that provides a temporary

resolution of this dilemma. Drinking alcohol in our society permits the individual to live for the moment, liberated from the need of approval from others. The effect of alcohol produces a feeling of competence which results in a sense of independence. The drinker feels he is his own man. Now he is running his life, he is involved, he has no doubt about himself: he no longer needs approval from others. Initially, alcohol is a most effective agent for the resolution of the dilemma. However, its very effectiveness contributes to the progressive nature of the disorder that will later develop. Because alcohol is effective and because its use is widely accepted, the individual does not have to come to grips with the real cause of his anxiety. The rate at which alcoholism develops depends on the intensity of the conflict and the encouragement received from the culture. It is my belief that very early in the process a degree of circularity introduces itself. The individual drinks to relieve the conflict outlined above but his sober recall of his behaviour while drinking aggravates the basic condition, strengthening the need for more alcohol. Eventually, a point may be reached where the basic psychological conflict is relatively unimportant in terms of explaining the individual's current behaviour. At this point he may simply be trying to drink away the problems that were caused by drinking.

"How can we help?"

If what I have said so far about alcoholics is true, we are now ready to ask the question: "If we would like to help them, what does this theory suggest about the procedures we should follow and the treatment program we should devise?"

The first thing we need to consider is to remind ourselves of the drinking climate from which the problem drinker has to emerge in order to seek help. As I said earlier, drinking in our society, or certainly within certain sub-groups of our society, is identified as a manly practice—a sign of strength, etc. Thus the heavy or incompetent drinker is going to feel that to acknowledge the need to get help because of the way he drinks will be the same thing as admitting that he is not a man, and this fact alone

will operate against his seeking help. In addition to the prevalent drinking attitudes, which make it difficult for the person to acknowledge the presence of a problem, there is also the fact that the attitudes toward the incompetent drinker are primarily attitudes of hostility, disgust and at best a kind of condescension.

When these and other attitudes are combined with the fact that most of the problem drinker's experience in living is associated with drinking, and that whatever pleasure he derives is derived through drinking, it is little wonder that he finds it extremely difficult to acknowledge either to himself or others the need for help—let alone demonstrate a willingness to seek it out. Because of these factors it is important that a treatment center for alcoholics be organized in such a manner as to facilitate the patient's easy entrance into treatment. We should also recognize that in most cases the patient's decision to seek help has not been one that he has reflected on for a period of time and come to a rational decision about. It is far more often the case that he is responding to the pressures that have resulted from his behaviour. These pressures may be external pressures applied by his employer or his family, or they may be pressures resulting from the pain that he is suffering due to his excessive behaviour. In any case, it is important for us to remember that his notion of being well or of being better at the point of his initial contact with a treatment agency is likely to be far different from the notion of recovery held by the staff of the agency. It is certainly true that the majority of alcoholics coming for help do not really desire a lifetime of total abstinence. It is far more often the case that what they desire is immediate release from the pain of the moment.

Attitude to the patient

These and other factors suggest first of all that the administrative hurdles should be kept to a bare minimum and that every effort should be made to meet the patient initially at his own level. It is important that the location, physical appearance, layout and furnishings of the treatment center be carefully considered insofar as they may communicate an attitude toward the

disorder and toward the people who suffer from this disorder. The building housing the treatment service should be respectable in appearance and located in a good neighborhood and while its purpose should not be hidden, by the same token it should not be advertised with large neon signs. Inside it should be decorated and furnished in such a manner as to contribute to a warm and friendly atmosphere. These and other factors are important in communicating to the patient that someone considers that people who are alcoholic are entitled to dignified and respectable surroundings and that there should be no serious stigma attached to the disorder.

A climate of respect

Of far greater importance than the characteristics of the building or where it is located is the orientation and the attitude of the treatment staff. If the alcoholic is characterized by a long-standing feeling of dislike for himself, which is intensified by the consequences of his drinking behaviour and his awareness of the attitudes the general public has toward people who drink excessively, then it is extremely important that all of his experiences associated with the treatment service should suggest to him that he is a person who is worthy of love and respect—or, at least, that he can become such a person. This means that above all else the attitude of the staff must be accepting and respectful. The staff should be individuals who believe that within every human being there is at least a spark of dignity and self-respect, and their approach to people should be characterized by a manner that will nourish the spark and cause it to burn with growing intensity. But because the alcoholic is also characterized by a refusal to be responsible, acceptance must not be confused with a sentimental permissiveness that prevents the setting of reasonable limits. In other words, the staff should be the kind of people who can provide a climate of acceptance and respect for the individual but who are at the same time able to draw reasonable limits and are willing to communicate that all of the patient's behaviour is not accepted or condoned, or even tolerated. It is difficult but it is possible to reject behaviour without

rejecting the individual. Anyone working with an alcoholic needs to be able to say: "I don't like the way you behave, but it does not follow that I hate you."

Non-intervention

Since a goal of therapy must be to assist the individual in becoming responsible, it should be a very rare occurrence where the staff would intervene between the patient and the *fair and logical* consequences of his behaviour. A counselor helping an alcoholic should never, in my opinion, do anything for the patient that he is capable of doing for himself. The importance of helping the patient to accept responsibility for his own well-being has implications in the realm of physical treatment as well. In the treatment of alcoholics much, if not all, of the medication given is not aimed at curing the disease but merely in reducing the pain. When medication is prescribed for the reduction of pain the physician is communicating his belief that the patient's pain is more than the patient should have to endure. It is important to recall at this point that the alcoholic is an individual whose approach to life has been characterized by a desire for the immediate reduction of pain and that his method of achieving this goal has been through dependence on a drug. There are times in the treatment of the alcoholic when it is essential that medication be prescribed. However, if it is continued too long there is not only the danger of switching his dependence, there is also the very real possibility of reinforcing this major factor in his pathology. The patient must eventually learn that the absence of pain is not always a desirable goal. He must eventually come to realize that healthy adjustment is, among other things, the ability to cope in the presence of pain. The need to assist the patient toward responsibility also suggests that we use caution with respect to the use of concepts like "sick" and "disease" when discussing with him the nature of his condition. The alcoholic may be prone to evade the responsibility he has for his condition by hiding behind the "sickness" label.

Adhering to the practice suggested may seem a simple task. As a matter of fact, it is often very difficult. The alcoholic is a

master at getting people to do what he wants them to do and it is often very difficult for the person trying to help the alcoholic to maintain a consistent approach. Very often the alcoholic makes the demand that we do things for him which he is perfectly capable of doing himself. Very often he tries to involve us in standing between him and the consequences of his behaviour and if we refuse to do this he is very quick to accuse us of not wanting to help him. This may generate anxiety in the therapist which results in him either, on the one hand, becoming hostile, or, on the other hand, conceding to the patient's demands.

Learn from mistakes

In relating to this kind of individual we need to recall what was said earlier about some of his characteristics. He will, for example, try to make you become his conscience; and yet if you fall too quickly into this trap he will resent and rebel against any direction that you give him. This means that any necessary direction must be given in an extremely careful manner. The manner I find most helpful is to outline a situation that has implications for the patient in a manner that allows him to identify with it, rather than telling him directly what he should do. This is the technique that is found to be most effective in Alcoholics Anonymous. We need to recognize that what we are trying to do is create an atmosphere in which the individual feels safe enough to start making his own choices and to be responsible for them. In order to do this, we need to be exceedingly careful about the goals we set. They must not be too high initially and we must find some way of discouraging the patient himself from setting unrealistic goals. It is often the case that the alcoholic wishes to solve all his problems at once. In order for him to make a commitment and to be responsible for his own choices he needs to learn that it is safe to make mistakes; this implies that the therapist has to be willing to allow the patient to fail and have the patient learn from his failures that they do not necessarily result in rejection and hostility.

I believe that it is almost impossible in the initial stages of counseling with an alcoholic for the therapist not to become a

model. This imposes certain responsibilities on the therapist which he may not wish to accept. However, I believe if he is going to be of help to the alcoholic there is no alternative. The therapist must be consistent and at the same time he must be able to expose his own humanity. For example, when the patient makes him angry I think it will often be appropriate for the therapist to acknowledge this fact. In so doing, the therapist acknowledges that he is human but also demonstrates that experiencing an emotion does not have to result in uncontrolled behaviour. It is extremely important that the counselor or therapist recognize that when he agrees to try and help an alcoholic he is making a moral commitment, and that once he starts he is not free or should not be free to give up just because the going gets a little bit tough. I think above all it is important for the therapist to recognize that for a time at least he will represent to the patient the kind of human being that it is possible to be without depending on alcohol. This means, at least insofar as the therapist's relationship with the patient is concerned, that he needs to be meticulous in living up to and practicing what he is preaching.

Finding a new faith

If one accepts the point of view I have presented, it is obvious that a major concern in treatment relationship with an alcoholic is creating an atmosphere conducive to the development of character. The alcoholic has made the bottle a substitute for faith, and it has failed him. Now he needs a new faith. It is not necessarily the counselor's job to tell him what his new faith shall be, but it is his job to help him find it.

A characteristic of a man endowed with a strong character is the ability to predict himself. He comes to know himself as a person who will in all probability do what he has committed himself to do. He knows how he will behave in strange and unfamiliar situations. This must be a major factor in self-confidence: "I know who I am and what I will do." Achieving this state of affairs is the major goal in helping the alcoholic. However, we must take into account the fact that the alcoholic has avoided,

for most of his life, a solid commitment to anything; and whenever he has made commitments these have been characterized by failure. For example, it is entirely likely that prior to his coming for treatment he has committed himself to the notion of sober living many, many times; and each time he has failed. He has reached the stage where he will not make further commitment, because each failure is a further blow to whatever confidence he may have left in himself. For this reason, and because of the circumstances he is likely to be in when he seeks help, we must be careful that the accomplishments or goals he sets for himself are small goals capable of being realized and we must enable him to come to see that his responsibility is really no different from anyone else's and that all he has to do is to try and live sensibly now. The road of recovery for the alcoholic as he first starts on it is very long and very steep, and is frequently overwhelming. If he can be encouraged not to look ahead too far but to focus his attention on the things he can accomplish today, he has a chance of succeeding; and each day that contains some kind of success is a re-inforcement for future accomplishment on succeeding days. We must appreciate that if the alcoholic resembles my description at all, recovery means far more than giving up alcohol. It requires for him the development of a new way of life. Necessity has forced him to come to grips with some of the fundamental and terrifying questions of life. Unlike so many of us who live in reasonable comfort all our lives without concerning ourselves with these basic issues, the alcoholic, by the very method he has chosen to help him forestall this occasion, is forced into it. The alcoholic has to resolve the dilemma, "To be or not to be."

A.I.T. Addictions

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The Foundation has offices at:

Toronto (365-4521)—24 Harbord Street
—221 Elizabeth Street
Toronto (East) — 1468 Victoria Park Avenue (751-0955)
Fort William—1020 Victoria Avenue (622-1735)
Hamilton—143 James Street South (525-1250)
London—477 Waterloo Street (433-3171)
Ottawa—1206 Bank Street (733-8343)
Sault Ste. Marie—674 Pine Street (256-2226)
Sudbury—166 Douglas Street (675-1195)
Windsor—961 Ouellette Avenue (253-1382)

Editor: Alasdair McCrimmon

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SUMMER, 1966

The First Fifteen Years

— extracts from the Chairman's report

by S. R. Stevens, Chairman of the Foundation

(from the fifteenth annual report of the Alcoholism and Drug Addiction Research Foundation, March, 1966)

In the decade and a half since the work of this Foundation began, its activities have developed from those of one small experimental unit into those of an integrated and widespread program which now embraces clinical facilities throughout most of the province, a province-wide program of preventive education, and simultaneous programs of clinical, biological, psychological and social research.

During its first fifteen years, the Foundation has:

- carried out or sponsored 165 research projects in scientific fields related to addiction;
- set up in separate Ontario cities twelve alcoholism clinics, which have provided treatment services for several thousand alcoholics and an increasing number of persons addicted to other substances;
- provided training services, based on the Foundation's growing knowledge about addiction, for professionals in

medicine, social work, religious counselling and other fields where help can be found for the addict in the community; and — established the Foundation as an impartial and helpful source of information on alcohol problems and on addiction generally, bringing, through publicity and education, greater understanding of these problems to many citizens.

Ready to expand

Fifteen years is not a long time in which to come up with satisfactory answers to a public-health problem that society has been facing for centuries. Nor have we found all the answers; however, by concentrated effort, the Foundation's activities have now placed the provincial health authorities in a position to begin expanding treatment and preventive services in the field with some confidence that they are following procedures that, based on the most up-to-date knowledge, appear most likely to succeed.

When the Foundation's work began, there were not many competent people available to plan and undertake the types of research required or to provide clinical and educational services. Only gradually has it been possible to involve enough of the workers needed, either as members of the Foundation's own staff or through sponsorship by grants from the Foundation for research and other purposes.

Now that the Foundation's own working team has begun to approach the size that the problem calls for, we are devoting more and more attention to conveying the Foundation's increasing knowledge to the professionals and others who deal with present and potential alcoholics and drug addicts. The need to expand the number of professional people with some training in this field has led to priority being given, in proposals placed last year before the Government, to development of the Foundation's special training facilities in close

liaison with the universities in Ontario that are providing the more general aspects of professional health training.

Completion of plans for our new central institute on the University of Toronto campus during the past year has been a big step towards fulfilment of our professional training function. It is earnestly hoped that this institute will be complete in time for all the Foundation's central Toronto programs to move into it in 1986.

For several years now, the Foundation has carried on a wide variety of special training programs through our regional units, for such professional groups as nurses, social workers, probation officers, police officers, clergymen and teachers. From time to time special refresher courses for physicians have been run in collaboration with the College of General Practice. Post-graduate students in medicine and other health sciences have always formed a part of our clinic staffs. In addition, since 1962, an annual two-week residential summer school has been run in collaboration with major universities in the Province.

The Foundation also recognizes the unique contribution being made in this field by the activities of Alcoholics Anonymous and of various professional and religious groups throughout Ontario. The Foundation wishes to encourage independent efforts to deal with addiction problems, and to provide all possible aid to them in improving the quality, usefulness and extent of their services.

Last Year's Activities

— extracts from the Executive Director's report

by H. David Archibald, M.S.W.,

Executive Director of the Foundation

During the year 1965 this Foundation's programs of research, treatment and education continued to expand. All types of chemical addiction — to narcotics, sedative and stimulant drugs and to alcohol — are involved in these programs, but the most widespread of these disorders is still alcoholism.

A special review of activities related to alcoholism was undertaken last year and a plan for dealing with this problem during the coming decade was presented to the Government of Ontario. In the statement by the Minister of Health, reporting the adoption of this plan by the Government and proposing it to the legislature, it was announced that:

"The Government of Ontario is prepared to declare alcoholism a public health problem requiring for its prevention and control a complete program of education and information, early detection, treatment and rehabilitation, together with continuing research. The Alcoholism and Drug Addiction Research Foundation will play a leading role in such a program, in co-operation with other government and private organizations and agencies of Ontario."

This is a very broad assignment. Ontario's present alcoholic population of 90,000 to 100,000 people will reach 120,000 in twenty years, based on population increases alone, unless in the meantime our prevention and treatment activities are greatly expanded. Not only must we develop more widespread application of known methods of treatment and prevention, but also, through continued research and professional training, we must constantly improve their quality and effectiveness.

The research that has been done to date in this field has already contributed a great deal to our understanding of various aspects of the problem. Research has greatly clarified what is

known about the categories of alcoholics that can be treated most successfully, and the variety of treatments that are appropriate. Even so, the degree of success that can be anticipated from known treatments — even for the types of patients most likely to succeed — still leaves much to be desired. Only a continuation of the multi-pronged research attack that the Foundation is now making on this problem holds forth any real prospect of a striking reduction in the number of people who develop alcoholism, or in the time and effort required to improve the condition of those who become alcoholics.

Research

The Foundation's research goals are to find out what happens, socially, psychologically and physiologically, in the development of various types of alcoholism and other addictions, and what the most effective means are for interrupting these addictive processes and remedying the damage they do to the health of those affected.

Research in this field involves a broad variety of specialized endeavours, which are being carried on by more than 150 highly-trained people on the Foundation's own staff and in universities and hospitals that receive grants from the Foundation for specific projects. Included are theoretical and statistical studies, field surveys, experimental laboratory work and continuous study of addicted patients.

The Foundation carries on clinical research in several of its clinics, and at Toronto it also maintains a research division which is divided into four departments: biological studies, psychological studies, social studies, and publications and documentation.

Clinical

While clinical studies are carried on mostly in the Foundation's own clinics, a few are undertaken elsewhere with Foundation support in the form of grants. During 1965, a variety of statistical studies of the characteristics of alcoholics were continued, based on the large volume of patient records accumulated

by the Foundation. At the London branch, a second study of the use of LSD in psychotherapy is under way. At Kingston, continued follow-up is being done on patients who have received the unique Scoline treatment developed there. It has become evident that Scoline treatment — a type of aversion treatment — is not highly successful by itself, but that it may have a useful role as part of a broader treatment program with selected patients. Both at Kingston and in Toronto, procedures are being instituted that will make it possible to compare conditions related to many aspects of the social, psychological and physical health of patients before and after treatment. This is of particular importance since a multitude of factors other than drinking behaviour may be involved in improvement resulting from treatment.

Several studies are under way on patient motivation (London) and methods of arriving at prognoses for incoming patients (Hamilton). In both Toronto and Hamilton, surveys are being conducted on the association of various organic diseases with alcoholism, and in Toronto an attempt is being made to assess the mortality experience of all patients admitted to the central clinic between 1951 and 1963. In Toronto, too, an exploratory study has been started on the effects of parental alcoholism on children.

Biological

Biological studies are undertaken largely through a block grant in support of a team of scientists in the pharmacology department of the University of Toronto, but a number of grants are also made to persons undertaking specified projects in other university departments in Toronto and elsewhere.

Some of the biological work involves direct study of changes in the condition of patients, and therefore might also be considered under the heading of clinical studies. In this category is a comprehensive study of the changes in body chemistry that occur in patients undergoing withdrawal from severe intoxication.

Other parts of the work are primarily laboratory investigations. Current laboratory work, mainly at the University of Toronto, is concentrating on the metabolic and cellular basis of

increased tolerance to alcohol. This work is providing useful evidence of the role of biological factors in some of the principal symptoms of alcoholism, such as the inability to stop drinking once one has started, and in the withdrawal reactions.

Psychological, Social

Some grants are made for psychological projects outside the Foundation, but most of this work is now undertaken within the research division in Toronto — particularly now that the division's animal laboratory, established in 1964, is in full operation. A number of studies of the behavioral effects of various doses of alcohol are under way in Toronto and at certain of the regional clinics. In the Toronto laboratory, new methods of administering intoxicants and measuring their effects on animals have been developed. Some projects are also concerned with the effects on behaviour and learning of some ingredients of marihuana.

A wide variety of social studies are under way. A major study, now completed, is a multi-disciplinary investigation of the chronic drunkenness offender. Some of the findings of this study have been given fairly wide publicity through their incorporation into future policy recommendations by the Foundation, and the full study is currently being prepared for publication.

Two other major field studies are in progress: a re-survey of the total alcoholic population of an Ontario county, and a large-scale study of drinking behaviour and alcohol problems among Indians in Ontario reserves. The scientist responsible for the latter project has been consulted extensively in the planning of an alcoholism program for the far northwest part of the province. Work is also continuing on the extensive data collected during a number of years on beverage alcohol purchases of various types in different areas in Ontario.

Publications and documentation

The publications and documentation work includes the Foundation's developing archive of literature on drug addiction. As a result of liaison with various information-gathering projects in the United States, the archive will emphasize the non-narcotic seda-

tives, stimulants, tranquillizers and hallucinogens. By the end of 1965, nearly 3,000 abstracts had been collected, together with many thousands of articles about these drugs.

Treatment

In 1965, the Foundation's treatment services provided some treatment to about 3,300 patients, just under half of these being new patients that year. The additional services we began during 1965 should bring our total patient load up to nearly 4,000 during 1966. Within a year or so, we will be operating or sponsoring about twenty separate treatment units in the province.

During 1965, the Foundation began, continued with or completed the following additions to its services:

Windsor: opened a regional office;

London: expanded clinic premises to accommodate about 600 patients a year;

Hamilton: moved the clinic to larger premises; provided a grant-in-aid to a new halfway house that had been initiated privately; proceeded with arrangements for a new 50-bed teaching hospital;

Toronto: increased the capacity of the present teaching hospital to 24 beds — roughly half for acute and detoxication cases and half for a long-stay continuing-care program; provided separate facilities for the day-treatment unit, which had been part of the teaching hospital; provided a social and recreational centre for former patients; established an experimental halfway house; proceeded with arrangements for a 50-bed detoxication and screening unit for chronic drunkenness offenders; completed plans for a 100-bed teaching hospital and an extensive out-patient clinic as part of the new Foundation provincial headquarters, which is scheduled for completion in 1968;

Kingston: expanded the experimental unit in the Ontario Hospital to 20 beds;

Ottawa: increased the caseload of the unit and extended its consultation services to other communities in the Eastern Ontario region;

Sudbury: opened out-patient services;

Sault Ste. Marie: opened a consultation centre;

Fort William: reorganized consultation services in larger quarters.

While we expect further growth in the patient load of the Foundation's own services, it should be stressed that the indefinite expansion of specialized clinical facilities is very far from our aim. Instead, we hope that the experience gained in our specialized facilities will find its way into widespread use by all the healing professions and services throughout the province.

It is particularly important that general hospitals throughout the province should more and more see their way clear to providing services for alcoholics on both an in-patient and an out-patient basis. Developments in treatment technique that have taken place in the Foundation's own units during the last few years make it possible to eliminate many of the difficulties that formerly made hospital staffs reluctant to deal with alcoholics. It only remains to convey these techniques to more and more professional people in health institutions and in outside practice and services.

In view of the wide variety of services that can become involved in the management of addicts at various stages of their recovery, the Foundation has begun to assist some independently-established treatment and rehabilitation projects through a limited program of grants-in-aid. We hope that this program can be expanded in future years, since it can play a major part in increasing the amount of local initiative involved in efforts to deal with this problem.

Prevention and Education

Preventive activities are of two main types: primary, before any problem arises; and secondary, interrupting alcoholism in its early stages.

Primary prevention is fundamentally an educational task. Its main goals are greater public understanding of the ways of drinking that are harmful and greater ability to recognize them, and a climate of social disapproval of voluntary drunkenness rather than of drinking as such. Education of youth through teachers

in schools needs reinforcing through parents and through other adults who may be significant in the lives of young people. This calls for a considerably enlarged program of public education and publicity.

The role of law

Primary prevention may also be partly a legislative task. However, there is a good deal yet to be learned about the role of law in this field. It seems likely that the direct effects of legal measures to control the amounts, times, places and costs of alcohol consumption are not as influential as their indirect effects on the whole social environment of the drinking situation. Potentially the law could help to create environments that would be more conducive to moderate drinking than some are at present. It should be possible to de-emphasize the drinking function in places where drinks are served, by heightening the importance of other activities.

Secondary prevention is basically a matter of case-finding and the encouragement of treatment at the earliest possible stage in the development of the individual's alcoholism. Early recognition of incipient alcoholism can be encouraged through professions and agencies that deal with health and welfare problems, law-enforcement procedures and other agencies of control such as driver-licensing authorities, and persons in authority in employment settings. All of these need to play a more active part in recognizing the early symptoms of alcoholism and handling them, not as misbehaviour to be either tolerated or disciplined, but as reasons for insisting on referral to health services; this brings incipient alcoholics into treatment before their rehabilitation problem has become too serious.

In summary, prevention seems most likely to be achieved by:

- expanding the present youth-education programs in the schools;
- expanding the advertising and publicity that reaches adults;
- developing a legal framework that will encourage the types of institutions, recreational activities and law-enforcement procedures that can indirectly minimize the role of drinking in modern living;

- developing industrial programs with a view to the earliest possible recognition and treatment of pre-alcoholic symptoms;
- developing and expanding existing community programs for early detection and treatment of alcoholism; and
- affecting the climate of the community so as to encourage people with drinking problems to come forward for help, and so as to support recovering alcoholics during their period of rehabilitation.

The education program of the Foundation is now directed mainly towards the young, the employed, people with addiction problems and people who can help them. We have sought to help as many people as possible to avoid trouble arising out of the abuse of alcohol and other drugs, and to let all people, including those whose business is treatment, know that alcoholics and drug addicts can be helped, and how this can be done.

We approach young people directly, through the school system — particularly through physical and health education teachers — and indirectly, through advertisements and literature aimed at parents. This year, material about alcohol and its effects was introduced in Grades IX and X for the first time. Formerly this material was included in the curriculum at the Grade XII level only, and of course many young people drop out of school long before Grade XII.

Approaching employers

Half the alcoholics in Ontario are fully employed, and treatment has been shown to be much more effective when the alcoholic still has a job. The Foundation's education division worked with about 50 major employing organizations during 1965. Twenty of these were interested enough to send their chief executive officers to specially arranged top management meetings on alcoholism. Following the top management meetings, these companies sent senior management men to 2½-day seminars on alcoholism, also arranged by the Foundation. We have had an initial meeting with senior representatives of the Ontario Federation of Labour, and we have assurances of further conferences with the various labour unions.

Looking Ahead

Like most other public-health organizations, the Foundation seeks to guide its projects towards the greatest good for the greatest number of people. Given limited resources, this means that choices must be made between different approaches to the total number of potential patients. There seem to be two basic approaches:

- towards easily definable and accessible groups that are clearly needy segments of the population, though they are poor prospects for recovery: for example, skid-row chronic drinkers and street narcotic addicts;

- towards less accessible groups such as industrial workers, whose employment and family ties make them relatively good prospects for recovery.

Needy groups

The Foundation is on the point of starting, initially in Toronto only, a detoxication centre which will try to work with the skid-row chronic drinker without having the traditional charge of public drunkenness laid in court. An attempt will be made to treat the people who are commonly called chronic drunkenness offenders as sick people rather than as offenders.

The centre's basic purpose will be to assess the condition of each patient and refer him to the type of treatment setting that is most suitable to his condition. This might turn out to be out-patient services, a halfway house or possibly some rural setting. These referral facilities are regarded as part of a package that includes the detoxication centre; it is important that all parts of this system be ready to begin operation at about the same time.

The Foundation's narcotic addiction unit has now completed two years of operation. Basically a combined out-patient and day-treatment centre, it also makes use of our Toronto in-patient centre for some patients needing hospitalization while undergoing withdrawal — that is, while suffering the ill effects associated with being weaned from physical dependence on their drug.

Another group of patients has been put on prolonged withdrawal or maintenance therapy. The proportion of patients on maintenance was increased in the second year of operation when the unit was merged for administrative purposes with the adjacent out-patient alcoholic clinic.

While it is too soon to present any complete evaluation of these pioneer programs, it appears that to date about half of both the short-term and maintenance patients have remained in therapy satisfactorily. The courts are starting to refer some cases to the unit, sometimes on probation.

It is known that a far larger number of persons are addicted to various sedatives, energizers, tranquillizers or hallucinogens than to the traditional narcotics. In addition, there has been much interest recently in marihuana, which is classified by the law as a narcotic but is not generally regarded in scientific circles as addicting in the same sense as heroin and similar opium derivatives. Current marihuana users in Toronto do not appear to come mainly from the same part of the population as the heroin users, being usually younger and often with no criminal record. A special clinical investigation program has now been set up to deal with marihuana users who are referred to us on probation by the courts.

Apart from the research archives project, no special projects regarding "other" drugs are under way; however, a number of barbiturate and amphetamine addicts do go through our clinics, frequently showing mixed addictions with alcoholism. This represents a challenging area that requires further investigation before any definite or distinct program can be proposed.

Alcoholic drivers

It is now almost a decade since some members of the Foundation's research staff estimated that about one-quarter of all persons convicted of drunk or impaired driving must be alcoholics rather than merely social drinkers. Subsequent research elsewhere has come up with a variety of similar estimates, nearly all of them suggesting an even higher proportion of alcoholics among convicted drivers.

If it could be arranged that all persons charged with impaired or drunk driving had to be examined by clinical experts on alcoholism, this might bring several thousand persons into treatment and at the same time take them off the roads for a while. In present practice, driving licences are suspended for varying periods; but they are later restored, more or less routinely, and usually without any attempt to deal on any clinical basis with those drivers who actually have a health problem. Clearly, there exists here an opportunity for dealing with two major problems at once.

Other drivers

While effective management of alcoholic drivers would take a large slice out of the accident-prone population, there still remain some non-pathological drinkers who become involved in accidents. Presumably these persons can only be reached by a combination of education and law-enforcement, but not necessarily of the traditional variety. It has been suggested that the present confused state of the law on impaired driving be replaced by an "alcohol limit" type of law, setting some reasonable percentage of blood alcohol that must not be exceeded, and requiring acceptance of the necessary tests. In medico-legal circles there is considerable support for such a law. It has also been suggested that educational information on this matter be made more realistic by stressing the need to wait before driving after drinking more than a certain amount, rather than simply condemning any driving after one drop of alcohol. The whole idea of limiting one's drinking at all times might turn out to be effectively supported by a realistic approach to one's alcohol limits in the matter of driving.

Employed alcoholics

Generally speaking, employed alcoholics are the best prospects for recovery, particularly when their employers co-operate in the process of recognition, referral and treatment. Large companies are able to do this through their medical departments. Smaller companies can also play an important role, mainly by not

covering up for an alcoholic employee but insisting that he take treatment as a condition of continued employment. The Foundation will very soon be setting up a special industrial clinic. While this new clinic will not be reserved exclusively for employed patients, its program will be aimed primarily towards their needs.

Toronto Clinical Services

— the Physician-in-Chief's report

by J. L. Silversides, M.D., F.R.C.P.(C.)

The Foundation's clinical activities in Metropolitan Toronto continued to expand and diversify during 1965. There was a very slight increase in the number of new patients, a somewhat larger increase in the number of patients already on the books who continued to receive service, and a considerable increase in the amount of service provided for each patient.

The year began with our activities centred in three separate units. It ended with six centres in operation and three more at an advanced stage of planning under key staff members who had already been appointed to run them.

In-patient unit. At 24 Harbord Street there are now 24 beds, of which some are used for an increasing flow of short-term patients receiving withdrawal treatment relating to alcohol or other drugs, and the remainder for longer-term continuing care of patients for whom such residential treatment is considered beneficial. The number of patients admitted to this unit remained about the same as in the previous year, but expanded capacity made possible the provision of somewhat longer and more intensive treatment. There was a marked increase in the number of withdrawal patients, with increasing use of this service for patients having various types of drug addiction; these latter now represent about ten per cent of the caseload.

Day-treatment unit. During the year, this service was separated in staff and physical accommodation from the continuing-care in-patient service, of which it had formerly been a part. Most of

the space at 30 Harbord Street, which formerly housed various general offices of the Foundation, has been turned over to this unit. The day-treatment concept is expected to become increasingly important in the Metropolitan area as a method of providing full-time treatment without the expense of hospitalization.

Central out-patient services. This is the largest service unit in the Foundation, and its activities increased very substantially during 1965. It occupies the entire first two floors of the building at 221 Elizabeth Street, which also houses the Foundation's central education and research divisions. Activities related to both alcoholics and persons addicted to narcotics and other drugs are carried on here, under the same general supervision but in separate parts of the building. About one-fifth of the time of the professional staff is devoted to activities with narcotic patients.

Halfway house. Towards the end of the year, we obtained a property for an experimental halfway house on Madison Avenue, about three blocks from the Foundation's in-patient and day-treatment centres. We acquired supervisory professional staff for this unit and began necessary alterations in the building so that this new service could go into operation early in 1966.

The 345 Club. This is an independent activity run by patients and former patients in a house provided by the Foundation on Huron Street, close to the in-patient and day-treatment units. In effect, it is a recreation centre that provides much-needed social support for persons recovering from alcoholism. It is run by its own board, on which the Foundation has a representative.

East Toronto branch. This unit continues to provide out-patient services, mainly on a group basis, to patients in the northeast part of the Metropolitan area. Its staff have been asked to take part in planning future clinics for other suburban locations in the Toronto area.

Detoxication centre (planned). Under present circumstances, the homeless chronic alcoholic is simply processed repeatedly through the courts on drunkenness charges. In order to deal more effectively with this problem, the Foundation has made plans for a detoxication and assessment centre and also for certain out-of-town rehabilitation areas. Key professional staff have been

acquired to direct these facilities, and it is expected that they will begin operation at some time during 1966. The detoxication centre will be located in downtown Toronto and will have about 50 beds.

Rural rehabilitation area (planned). For long-term care of some of the homeless chronic alcoholics, the Foundation is planning to establish some rehabilitation farms. We have examined various properties, and members of the professional staff have been designated to take over this program.

Industrial-residential clinic (planned). As a result of considerable discussion with interested executives of large employing organizations and of the unions that serve their employees, it has been decided that the next suburban service to be provided by the Foundation should be an industrially-oriented residential and out-patient clinic somewhere in the northwest part of the Metropolitan area. This clinic would concentrate on treatment of employees referred by their employers, probably with acceptance of treatment being a condition of continued employment. At the end of 1965, the Foundation was seeking both staff and facilities for this unit, which also is expected to begin operations in 1966.

Work continued during 1965 on planning for the new central research and teaching hospital, which is now expected to be in operation late in 1968. This is intended to re-unite under one roof the central in-patient, out-patient and day-treatment facilities, which are now in different buildings. However, such developments as the suburban clinics, the detoxication centre and its related services should continue to be separate entities in other parts of the Metropolitan area. As time goes on, the outlying facilities will be mainly service-oriented, while the central facilities will be more and more directed towards an emphasis on research and professional training, in full collaboration with the persons performing these functions at the University of Toronto.

Summary of Foundation Clinical Statistics — 1965

(1964 figures in brackets)

	Patients carried over from previous years	New patients	Total
Toronto central (including narcotic)	685 (570)	*473 (652)	1,158 (1,222)
East Toronto	103 (—)	142 (177)	245 (177)
Total Toronto	788 (570)	615 (829)	1,403 (1,399)
Lake Erie (London)	262 (256)	209 (214)	471 (470)
Eastern — Ottawa	186 (170)	208 (183)	394 (353)
— Kingston	38 (—)	95 (38)	133 (38)
Hamilton	335 (80)	299 (275)	634 (355)
Northeastern (Sudbury)	— (—)	90 (—)	90 (—)
Northwestern (Fort William)	73 (50)	112 (117)	185 (167)
Total	1,682 (1,126)	1,628 (1,656)	3,310 (2,782)

*As a guide to the proportion of alcoholic and narcotic patients in the central Toronto clinics: of the 473 new patients, 393 were classed as alcoholic, 38 as narcotic, 12 as non-narcotic and 30 as mixed additions.

Treatment of Alcoholics

at the Foundation's Toronto clinical services

by J. Gregory Fraser, M.D., F.R.C.P.(C.)

Patients are referred to us by physicians, general hospitals, mental health clinics and hospitals, social agencies, Alcoholics Anonymous, legal authorities, ministers, and employers. There are some self-referrals.

Most patients who come to us for help have had a pathological drinking pattern for years. During this time, alcohol has become so important in their lives that they have not been able to endure the thought of living without it; for this reason, they have denied the existence of their problem.

When an alcoholic does come to us, it is usually because he fears losing something in his life that is more important to him than alcohol. He may fear losing his family, or his job; his health, physical or mental, — through liver damage, central nervous system damage (blackouts and seizures) or the withdrawal syndrome; he may fear losing his freedom — after a conviction for impaired or dangerous driving, or for assault or robbery when impaired; he may have a combination of two or more of these fears.

His initial contact with us is with the out-patient department. Regardless of referral source, the patient is asked to call the clinic to make his own appointment — from the very outset of treatment, he is asked to do something himself.

When he comes to the clinic, he is seen first by a clinic nurse. She records basic information on the patient; she obtains an outline of the patient's drinking history, and his family, working and social life; and she arranges for routine laboratory tests, including hemogram, urinalysis, chest x-ray, and Wassermann.

The patient then sees a physician who, in one or two interviews, obtains a detailed medical history and makes a complete

Dr. Fraser is clinical director of the Foundation's in-patient and out-patient clinical services in Toronto. This article is adapted from a lecture that Dr. Fraser gave to several groups of public health nurses this spring.

physical examination. The physician obtains enough information to decide whether further assessment is required by a social worker, psychiatrist, psychologist or pastoral counsellor.

Following assessment, the patient is discussed — either formally at a meeting of the clinic team, or informally among the staff concerned — and a plan of treatment is agreed on; this is modified if need arises.

Withdrawal treatment

At the time of the patient's initial interview, he is often in need of withdrawal treatment. This is done in our medical unit or in one of several general hospitals.

Withdrawal treatment is relatively easy to manage: it consists of bed rest; dietary measures — a bland high-protein diet initially, later a balanced diet with appropriate proportions of protein, fat and carbohydrates, and often vitamin supplements; tranquillizers and sedatives; anticonvulsants; nursing care; and occupational therapy.

At the time of admission to the medical unit, we look for and often find head injury; infection — lung, skin and subcutaneous, or genito-urinary; liver insufficiency or cirrhosis; gastritis, peptic ulcer or hemorrhage. Less often, we find an acute abdomen — for instance, acute pancreatitis; vitamin deficiencies — beriberi and the like; or certain neurological complications.

With the treatment regimen described above, improvement is often remarkable after only a few days.

Before the patient is discharged from the medical unit, I think it is important for the physician to discuss with him the reasons for his admission. At this time it is especially difficult for the patient to deny that he has a problem with alcohol; and despite his tendency to project and rationalize, his defences can often be penetrated. It is often possible to reinforce the patient's desire to stop drinking by discussing what he can expect if he continues to drink.

Following treatment in the medical unit, the patient may return to the out-patient department for continuing treatment or he may be referred to one of our intensive-care units — the day-

treatment unit or the continuing-care unit — for a period of intensive therapy.

The day-treatment unit and the continuing-care unit are similar enough that they may be discussed together. Patients are eligible to take part in these treatment programs if:

- they reside in Metropolitan Toronto;
- they are willing to spend six or seven weeks in the treatment program;
- they are willing to abstain from alcohol or their other addictive chemical while in treatment;
- they are free of physical or mental damage or disorder that would preclude their participation in the group therapy program; and
- they have the potential for change, especially in their adaptation to stress.

In the continuing-care unit, the patients are admitted in a group and remain for six weeks. They stay in the clinic 24 hours a day except for attending planned social events in the community or returning home at weekends when this is considered therapeutic.

In the day-treatment unit, the patients are also admitted in a group, and they remain in treatment for seven weeks. Day treatment has the advantage of letting the patient return to his family and social environment on weekends and after 5 p.m. on weekdays.

Staff and techniques

The staff in these units is multi-disciplinary and includes psychiatrist, social worker, psychologist, nurse, occupational therapist, recreational therapist, pastoral counsellor and consultant in internal medicine. Most of the staff in these units work full time.

The therapeutic tools of these units include group therapy; intensive diagnostic assessment — psychiatric, medical, psychological, social and spiritual; didactic lectures, discussion groups, films; occupational therapy and physiotherapy; pharmacotherapy — protective drugs, tranquillizers, antidepressants, nutritional supplements and others; and environmental study, including home

visits and interviews with families and interested persons such as employers.

During the initial group-therapy sessions, the patients get to know one another and the staff. In time, a group cohesiveness develops and a genuine trust and affection grows among the members of the group. As each member in the group becomes more secure, he begins to discuss the things in his life that are especially important to him: his feelings, his likes and dislikes, his insecurities, his tension and anxieties, his boredom and loneliness, his unhappiness.

Intensive care

➔ Intensive-care treatment has many goals:

- ① Breaking down the alcoholic's pathological defence mechanisms — his rationalization, projection and denial. This must be achieved if there is to be any real progress; often only a beginning is made, but this in itself can be an important step forward.
- ② — Developing insight into personality: you must help the person to know his strengths, his weaknesses, his ways of reacting to stress. Does the person who experiences rejection invite it by his own actions? How does he relate to his peers, or to an authority figure? How does he feel about himself? Does he repetitively become involved in a behaviour pattern that ends in disaster?
- ③ — Enhancing motivation: Does the patient want to stop drinking? Most patients are ambivalent about this; hence the patient should be conscious of the consequences of continued drinking and the advantages of abstinence. Since the initial abstinent period may be marked by insomnia, anxiety and tension, boredom and loneliness, irritability, anger and depression, the patient must be helped to deal with stress in a healthy manner. Often these symptoms become intolerable and the patient relapses. The therapist should not be discouraged by this.
- ④ — Learning or re-learning social skills: Many alcoholics spend much if not most of their leisure time in drinking; they must learn to occupy these hours more constructively and by means that give them satisfaction. For this reason, we place an emphasis on social and recreational therapy. In occupational therapy we hope that the

patient may learn a hobby or craft which he can continue when he returns home.

— Enhancing the growth of self-confidence and self-esteem: A patient's self-esteem is often enhanced by acceptance on the part of the other patients and the staff. Many patients are guilt-ridden because of their behaviour. Many patients feel worthless despite their actual achievements. As patients become more secure in the group, and as they participate more effectively, their self-confidence increases.

— Developing healthy relationships among patients, and between patients and staff. Most of us can appreciate the important and far-reaching effects that the development of healthy relationships can have on our lives; this is also true in treatment.

Following treatment in one of the intensive-care units, the patient is referred back to the out-patient department for continuing treatment. Successful rehabilitation of the alcoholic may take months and even years. Continuing treatment on an out-patient basis includes individual and group psychotherapy and counselling, pharmacotherapy and pastoral counselling.

When a patient is first discharged from one of the intensive-care units, he must be given much support. Patients may come to depend very much, even in six or seven weeks, on the clinic, the staff and the patient group. For this reason, patients should be prepared for their discharge long before it actually occurs.

Following discharge, they must be given the opportunity to discuss their problems with their continuing therapists. In out-patient treatment, it is not possible to provide the intensity of support that can be given in the day-treatment or continuing-care units; but during the transition period, as insecurity and self-doubt emerge again, giving the patient early help may be of the utmost importance. Success or failure in treatment may depend on provision of the appropriate support when it is needed.

Involvement of relatives

Relatives are involved in treatment in a variety of ways. Many relatives of alcoholics, usually spouses, contact the clinic for help because of a member of the family who is alcoholic and who

refuses to seek treatment. What does a wife who is living with an alcoholic husband need in order to help him?

- She needs much information about alcohol and alcoholism;
- she needs to learn that it is her husband who must make the decision to drink or not to drink;
- she needs to learn that she can be more helpful by letting her husband face the consequences of his actions;
- she must decide, with guidance, what steps to take to encourage her husband to seek help;
- if the family is in financial distress, she needs to know what resources in the community can help her; and
- if she decides to leave her husband, she may need help in carrying out this decision.

Some spouses of alcoholics need treatment themselves — spouses often contribute significantly to their partners' drinking patterns. This is often related to the satisfaction of an unconscious need to dominate and control, or to be a martyr.

Marital discord is common among our patients. From time to time we form groups of married couples, and the problems are discussed and sometimes resolved in group therapy.

A clinic that includes a variety of professions is especially fortunate in the treatment of alcoholics. Certain aspects of the patient's illness are medical, others are psychiatric, social, psychological or spiritual. The skills of each professional staff member are employed as efficiently as possible, but there is considerable overlap in the roles of the various disciplines involved. Certain aspects of treatment may be specific, but others may be successfully managed by any of the professions in the clinic.

Prospects of success

Our ultimate goal is the full rehabilitation of the patient, and this is achieved in a significant portion of the patients who come to us. Others will be improved, remain unchanged or deteriorate further.

This is by no means peculiar to alcoholism; it is characteristic in the treatment of most illnesses. Some patients are successfully rehabilitated following a relatively brief contact with a clinic and

with one or more therapists. Others may have intensive treatment and constant support by several therapists over a period of years without visible improvement. Sometimes our success is measured by what we can do for the family rather than by the change effected in the patient. Nevertheless, all patients can be helped — although this may sometimes mean that all we succeed in doing is alleviating their discomfort.

"Expert on Alcoholism"

Over and over again one sees the designation "expert on alcoholism" attached to the name of an individual working in this field. One must accept the fact that there are no experts on alcoholism; there are only people who are doing their level best to contribute something to the effort to study, treat and prevent alcoholism.

The individual who came closest to being an expert on alcoholism was a biostatistician — the late E. M. Jellinek — and he was the first to disclaim any expert knowledge. "I have bits and pieces of a vast puzzle," he once said. "But I cannot produce a clear, definable picture. Years of study are still required."

A pretension to expert knowledge satisfies the needs of many kinds of people, but in a disease so complicated and so frequently fatal as alcoholism, the title of expert is to be claimed only by someone who, in the future, finds the missing pieces in the puzzle. Meanwhile it is far better to be known simply as "a worker in the field of alcoholism."

— from *Perception*, a publication of the
Greater Boston Council on Alcoholism

Eight-Foot Bus, Seven-Foot Gap

An interesting experiment was carried out several years ago in Manchester, England, among a group of experienced bus drivers. They were divided into three groups: the first drank nothing before the test, the second drank two ounces of whisky and the third drank six ounces of whisky. Driving their own buses, these men, most of them moderate beer drinkers and all of them highly experienced drivers with no accident records, were told to manoeuvre their vehicles through the narrowest possible corridor without touching the side markers. They were themselves to indicate the width of the corridor they thought they could negotiate.

As the percentage of alcohol in their blood increased, the drivers become more and more cocky: one tried to drive his eight-foot-wide bus through a seven-foot-five-inch corridor, another insisted that six feet ten inches was enough. It is important to note that many of these drivers retained a wonderful degree of skill even after drinking six whiskies. They were still able to drive a double-decker bus at twenty or thirty miles an hour through a gap with only a half-inch or so on either side. But — and this is the crux of the matter — they believed they could do even better. The alcohol did not so much disrupt their performance as it affected their judgment. Even under the best of conditions there is a tenuous relationship between what we think we can do and what we are actually capable of doing. After the ingestion of alcohol, this delicate relationship tends to disintegrate.

—from *World Health*, the magazine
of the World Health Organization

Brookside Monographs

The University of Toronto Press this summer will publish the fourth in the Foundation's series of Brookside Monographs. The book is "Out-Patient Treatment of Alcoholism—A Study of Outcome and its Determinants," by Donald L. Gerard and Gerhart Saenger, both of New York. Dr. Gerard is a psychiatrist associated with the New York Psychoanalytic Institute, Montefiore Hospital and Linden Hall School; Dr. Saenger is chief psychologist at the Mental Health Research Unit of the New York State Department of Mental Hygiene.

The authors studied the treatment of alcoholism in a number of out-patient clinics and related in-patient facilities of state-supported alcoholism programs in the United States, and were thus able to investigate the influence of a variety of treatment programs on a variety of patients. They report that clinics play a valuable role in helping patients who are socially stable, but that they are rarely able to modify either drinking habits or other kinds of malfunctioning in patients who are socially deteriorated. They further report that improvement in drinking habits—either by abstinence or by controlled drinking—is related not only to what the clinic does but also to changes in the patient's social and interpersonal environment outside the clinic.

The foreword to the book is by H. David Archibald, the executive director of this Foundation.

Treatment of Narcotic Addicts

at the Foundation's Toronto clinical services

by S. J. Holmes, M.D., D.Psych.

The Foundation's narcotic addiction unit moved into its present quarters in downtown Toronto in October of 1963. Here we have begun to develop a co-ordinated program, offering:

- consultation on referral from other hospitals, agencies, doctors, etc., and

- out-patient management, in a modified day-care form, of the addict's medical, psychological and social needs.

The out-patient clinic operates on a 9-to-5 basis, Monday through Friday. Addicts needing in-patient treatment are referred to the Foundation's central hospital a few blocks away, or to an accepting general hospital.

The program of the clinic started mainly as an activity program, within which both withdrawal and rehabilitation were organized. The activity program with counselling, individual and group therapy and occupational therapy, was aimed at returning the addict to the mainstream of society in a drug-free state, as time and the patient's potential for development permitted.

In November of 1964 the entire out-patient treatment facilities of the Foundation, for both alcoholics and drug addicts, moved into premises at 221 Elizabeth Street. This gave us less space for activity and considerably modified our activity program. Thus we became more of an out-patient clinic, with a more regulated intake and examination procedure as well as day-care facilities with occupational therapy.

In 1964 we took our first step in expanding the treatment program by starting a social evening one night a week. We believe this should be extended to allow the clinic eventually to function seven days a week from 9 a.m. to midnight.

We use methadone, taken orally, to withdraw addict patients.

Dr. Holmes is senior psychiatrist at the Foundation. This article is adapted from a section of a paper entitled "A Treatment Approach to Narcotic Addiction," which Dr. Holmes delivered to several professional groups this spring.

We manage the withdrawal in two ways: short-term withdrawal and prolonged withdrawal or maintenance therapy.

In short-term withdrawal we give patients methadone daily, on a reducing dosage, for seven to 21 days — with medical, psychological and social support as we judge necessary. The average starting dose is 40 milligrams a day, divided into four doses. We have offered this treatment to 75 patients, from January 1st, 1964, to January 1st, 1965; of these, 37 completed withdrawal and 38 dropped out during withdrawal.

Maintenance therapy

Some patients cannot carry on satisfactorily after they complete their short-term withdrawal. Their motivation may be good in many ways, but they may show such symptoms as inability to relate satisfactorily at work or at home, aggression, restlessness, they may go back to the corners for an occasional fix, or their behaviour may be impaired by the use of alcohol or other non-narcotic drugs. This is the sort of patient we select for prolonged withdrawal or maintenance. We started this type of therapy in the summer of 1964, and up to the end of May, 1966, we had offered it to 69 patients.

In maintenance therapy the patient comes to the clinic every day for his supply of methadone, unless work and distance make it impossible. Patients who cannot come to the clinic every day get their daily supply from one central drugstore and visit the clinic once a week for new prescriptions and psychotherapy or social therapy. In some cases, where the patient seems stable and his prospects of rehabilitation seem good, he may receive his weekly dose in one package.

The daily dose varies from 40 to 10 mgm a day; the average daily dose is 30 mgm. We find that when a patient is on a dose he is satisfied with, he says that he does not get the high feeling he associates with heroin, but that nevertheless he has no desire for heroin.

We have made it a condition of the program that the addict must not use medication of any sort obtained by other means, must stay away from the corners and from addict society and

must be employed or actively seeking employment or some form of employment training. We believe it is imperative that the patient be employed, and the patient concurs; but employment possibilities for the addict are few and agency enthusiasm is meagre — so much so that it is a real bottleneck in therapeutic progress; it could cause failure of the program unless we can find a way to remedy it.

Relapses

We have had varied relapses to former behaviour during therapy. Patients have at times tested the treatment situation by using alcohol or other drugs, and by visits to the corners and to addict society. We evaluate this behaviour and interpret it to the patient, and when it becomes persistent we interpret it as a demand to be taken off the program.

In the 29-month period from January of 1964, when we began the narcotic unit program, to May of 1966, we have had 228 narcotic addict patients, of whom we offered methadone maintenance to 69. Of these, 32 have remained as active out-patients.

There is an urgent need for more experimentation in treatment approaches to narcotic addiction, because as yet no existing program is adequate. It is still too early for us to evaluate the results of our maintenance program, but we have seen considerable improvement in psychosocial development in many of our patients — in some cases, over a period now of eighteen months. Most have been working steadily, or have completed rehabilitation courses which their previous "street habits" prohibited. They have established themselves in living away from the corners, with the clinic and its activities the central focus of their interest. Some, for the first time in their lives, have bank accounts and bankbooks, which they proudly display. There are indications that some have been able to persevere through situations of adversity that would formerly have caused relapse and a return to active addiction.

Rounders and Squares

Peggy Ann Walpole's talk, which we reprint in the following pages, was originally delivered to an audience that was assumed to have some knowledge of drug-using groups in Toronto and of the slang used by their members. For readers who may not be familiar with the current Toronto drug scene or its vernacular, an explanatory note seems desirable — with the caution that the descriptions and definitions given here present a particular consensus of opinion, are for purposes of quick identification only and are not meant to be scientifically exact. One could argue for hours about the exact meaning of some vernacular terms — particularly rounder, hippie and square — and who is meant by a term such as square depends very much on who is using the term.

Who is a rounder?

Rounders are people who get their money largely by crime — generally petty crime — and spend it largely on drugs: alcohol, narcotics, amphetamines, tranquillizers. They hang out in the bars and restaurants of the area downtown whose focal point is the corner of Dundas and Jarvis Streets — a seedy, run-down area that is also haunted by many of the chronic drunkenness offenders.

Who is a hippie?

Both in Miss Walpole's talk and in the discussion that follows it, mention is made of some apparent interaction between the rounder group and what is referred to as the "Yorkville crowd." This is a group that hangs out in an uptown area called Yorkville Village, whose focus is the corner of Avenue Road and Yorkville Avenue. Yorkville habitués are popularly called beatniks, but are more likely to refer to themselves as hippies — from the adjective hip, meaning, roughly, in the know.

How hippies get money is not quite clear, but they seem to get by on very little. Some hippies work in legitimate jobs — typically, casual or transient jobs that require little or no personal

commitment: waiting on tables, washing dishes and the like. They spend their money on books, records, movies, listening to jazz groups and folk singers in the coffee houses, marihuana, amphetamines and LSD.

With very few exceptions, hippies range in age from the late teens to the late twenties. The youngsters in their early and middle teens who parade up and down Yorkville Avenue when school is out are not hippies — they are teeny-boppers. Many hippies complain that Yorkville has been spoiled — first by the teeny-boppers, who have been on the scene for several years, and more recently by the rounders, who seem to have been moving in during the last six months. Some of the older hippies have moved out of the Yorkville area entirely.

Who is a square?

In the gaslight era, square meant honest; this is still its basic meaning in the rounder sub-culture: a square, or square John, or do-right, is a person who is involved in organized society and shares its values — typically, a person who works at a legitimate job for a living. One way or another, rounders live off squares. Characteristic rounder ways of living off squares include theft, confidence games and prostitution. To a rounder, a square exists to be taken. When a square moves into a position in which he can be taken — for instance, by coming down to the corners drunk and with a full wallet — he is known as a mark.

To a rounder, everybody is a square except another rounder: for instance, a hippie is just another kind of square. Hippie is not a rounder term; if a rounder wanted to describe a hippie he would probably call him a beatnik.

Hippies view squares under a different light. Hippies think of squares as people to be avoided more than as people to be taken. The hippies' basic desire seems to be to stay away from the whole square scene — the 9-to-5 job, the car, the house in the suburbs — and pursue objects that they regard as more worthwhile.

Most of the rounders who are hard-drug users have probably smoked marihuana at some time, but the drug does not seem to appeal to them and they do not use it much. Conversely, there

seems to be very little evidence of hard-drug use among the hippies. Many rounders use alcohol; some get drunk and some are alcoholics. There is some use of alcohol among the hippies but little drunkenness, and there seems to be a strong social prejudice against drunken behaviour — to the hippie, getting drunk is something that squares do.

Who is straight?

Straight is used by many deviant groups to describe anybody who does not share their deviancy; for instance, marihuana smokers use it to describe anybody who does not smoke marihuana; they also use it to describe the state of not being high on marihuana. Homosexuals, both male and female, use it to denote anybody who is not homosexual.

Butch is a slang term meaning masculine; in a lesbian relationship, the butch is the partner who adopts the masculine role; the femme is the other one.

Goof-balls are capsules containing barbiturates. To be high is to be intoxicated, generally on a drug other than alcohol. A connection is a contact made with a drug pusher for the purpose of buying drugs; by extension, it is also the pusher himself.

Hustling is any kind of activity by which a rounder takes a mark, but particularly among female rounders it commonly refers to prostitution. Similarly, a hustler can be any rounder whose occupation is taking marks — a pool shark, for instance — but it commonly means a prostitute. An act of prostitution is a trick, and by extension, a prostitute's customer is also a trick. When a prostitute uses the term mark, she usually means a customer.

Street Haven

and the female offender

by Peggy Ann Walpole, R.N.

Street Haven is a non-sectarian organization designed to help rehabilitate the female offender — the woman who has been caught in the web of narcotic addiction, alcoholism, prostitution and petty crime. In April, 1965, the Haven was constituted as a corporation without share capital for this purpose and was authorized to accept and receive gifts and donations. The board of directors includes doctors, lawyers, clergy, officers of social welfare agencies and others — eighteen in all.

We opened our haven for girls on March 22nd, 1965, in a converted beverage room in the core of downtown Toronto — in the Atalanta Hotel at Jarvis and Carlton Streets. On March 15th of this year we moved to 2 Teraulay Street, just south of Dundas at the corner of Yonge.

The philosophy on which we operate is that no woman is an addict or a prostitute by nature; usually she is pressured into the life. All too often she is released from prison without money, without worthwhile friends, with no job and no place to go. When she returns to crime, it is for survival.

We try to provide for the emergency needs of women either when they leave prison or when they come in directly off the street. The Haven is not meant for diagnosis or professional therapy, but just to give help where it is needed and shelter to the girl who has come to accept the rounders' world as the normal. We hope by this to establish a point of contact between the square and the rounders' worlds and in this way to start girls on the way to re-establishing their lives.

More than 250 girls have passed through the Haven in its first thirteen months, and I think a significant number have shown signs of rehabilitating themselves.

Miss Walpole, executive director of Street Haven, gave this talk at one of the Foundation's professional study conferences, on April 22nd, 1966. It is reprinted here with her permission.

The Haven now occupies about 2,000 square feet over a store at the corner of Teraulay and Yonge. It has large windows and bright, airy living rooms with furniture that isn't new but is very comfortable. There's also an office now, which we didn't have before; this affords privacy for interviews. We have a telephone in the office, with an extension in the front room for the girls.

We keep the files and the daily log-book in the office. Some of the volunteers spend quite a bit of time in the Haven, but others only come in once a week, so the log-book helps them to keep up with what is going on. There's also a handbook that gives some rules for the volunteers — tells them what is expected of them; this also contains minutes of all the volunteers' meetings and the board meetings, so that a volunteer can keep up fairly well.

There is a large kitchen, which is being built by the T. Eaton Co. — it's going to be lovely.* We are in the habit of serving lunch at the noon-hour and informal snacks all day, and an organized night meal. The girls are expected to do their part — we encourage them to do the cooking and the cleaning up, with the volunteers' help.

Activities

For recreational facilities, there's a record player, radio, TV, ping-pong table, dart board — games of all sorts. There are various activities — for instance, we have a hootenanny once a week.

The girls have a team in the Ontario ladies' fastball league. Last year we were in a financial softball league and the team was sponsored by a trust company. This year the girls decided to finance the team themselves by running a raffle; the uniforms and equipment will cost them about \$600. I think the fact that they got into these leagues is very important; they felt very much accepted, playing with teams from banks and trust companies. Their first feeling was that the other teams would not want to play with ex-cons, drug addicts and alcoholics, but they seemed

*The kitchen has been finished since Miss Walpole gave this talk, and on May 24th the Haven opened a small public tearoom where they serve a light buffet lunch from noon to 3 p.m., Monday through Friday.

to accept them very quickly and the girls gained a lot of confidence in themselves.

The girls also have a bridge tournament going on, and their most recent endeavour was putting out a newsletter which we think is very good. It was completely gathered up by the girls, about 80 per cent of it was written by the girls and although it was set up professionally they were the ones who sought out the Varitypists to do it.

Some of the articles in the newsletter are excellent, and I have piles of material at home that couldn't be used, and I've been able to gain a lot of insight into a girl by the writing that she does, and the art work and the poetry. What I aim to do, as soon as we're settled in the new Haven, is some art work and crafts — clay modelling and copper work. The place is very large and will adapt itself very well to this kind of thing.

Discussion group

Other activities that go on in the Haven include a discussion group every Sunday night with a Youth Anonymous group from Hamilton. This group is mostly boys and young men who have also been in trouble. They came to hear me speak in Hamilton one time and decided that they would like to come down to Toronto and hold a discussion group with our girls. It has turned out very well for many reasons — because of the male being introduced into the Haven, and also the therapy of discussing their problems.

The girls conduct their own group therapy or discussions, sometimes three or four times a week. I would like to have a professional sitting in on these, on an informal basis. So far, many have done this: for instance, our directors who have been able to sit in on these discussions — the girls have learned to accept them as friends and are quite open with them.

The Haven is open from 9 a.m. to midnight Monday through Saturday and from 2 p.m. to midnight on Sunday. Our front window looks straight down on Dundas and you can see as far as Jarvis; this is the worst area for the drug addict. Directly behind us is Chinatown, where a lot of the drug addicts and

alcoholics hang out. North of us on Yonge near Wellesley, (a restaurant) has become quite a hangout, particularly for the younger set, and some of the Yorkville crowd is coming down too — something we didn't have before, when we were at Jarvis and Carlton.

Winchester Street

I also have a house on Winchester Street, near Carlton and Ontario, which we took over on January 15th of this year. This house came our way quite unexpectedly: the Haven couldn't afford to rent the whole house but we didn't want to let it go, so we set up a four-way lease on a 2½-year basis, in trust with two of the lawyers on the board of directors. I live over there now, and there's an office there where all the board meetings and the volunteers' meetings are held. In the basement there's an extensive used-clothing setup — clothes for girls who have come out of jail and are trying to outfit themselves and get jobs.

The other girls who live permanently in the house are girls who have rehabilitated themselves through the Haven. There are three girls living there besides myself — one has two sons; these girls have done very well in the last six months to a year, since they began coming to the Haven; they have become very involved, to the point where they are trying to help other girls. It was initially their idea to take over this house, and two of them have signed a quarter each of the four-way lease. These three girls come out on speaking engagements with me or with volunteers, and have been on TV and radio as spokesmen for the Haven. They have also been instrumental in organizing activities in the Haven, such as the baseball team and the newsletter.

Emergency beds

The Winchester Street house also has four emergency beds for overnight lodging. The girls who stay there temporarily, in the emergency beds, are expected to be out of the house from 9 a.m. to 10 p.m. — I can't supervise the place all day, so it can't be run as a regular halfway house. These girls are expected to

use the Haven in the daytime, if they aren't working or out looking for a job. And they must be in by midnight — we can't give them keys.

The emergency beds are for girls who have just been released from jail, or evicted for non-payment of rent or other reasons, or discharged from hospital, or they come in directly off the street and want help, or very often they are new in the city.

Afraid she would blow it all

Some of the girls who come on a temporary basis may end up staying longer: for instance, there was a girl who was on probation to us; we decided to keep her on a long-term basis. Another girl was discharged from hospital and needed to convalesce for some time. Another girl came out of hospital, got on her feet and got a job, and was afraid she would blow it all if she went out on her own to live. With girls like this we make more concessions about their coming in and out, so that they can feel more at home. We don't give them keys, but we do allow them to come and go a little more freely, so long as I'm there or one of the other girls who has taken over some of the responsibility of running the house.

Some of the community resources we have used over the last year are the National Employment Service, the Children's Aid Society, Legal Aid, your Foundation, welfare officers, Elizabeth Fry, Sancta Maria House, the Homestead, the Salvation Army emergency shelter, the Forensic Clinic, the Scott Mission, the Yonge Street Mission, the hospital clinics, the Institute for the Blind and the Adult Retraining Centre.

As an example of the help that has been given to some girls, we got legal aid for six girls who appeared in High Court in March as a result of drug charges they were picked up on last fall. This gave the girls a lot more confidence and the feeling that justice was being done — a little more faith in society. The two lawyers involved took great care and interest in the girls, I or a volunteer or both were always in court, which gave them moral support if nothing else, and we were treated with a great deal of respect by everybody in the court. The judge showed great

interest and concern; he spoke to me in his chambers about these girls, obviously wishing he didn't have to sentence them quite so severely because of their past records.

The girl who had the worst record of the six — she was possibly facing the "habitual" charge — wanted to further her education while she was in prison, and we helped her with that. While she was in the Don jail we were able to get her the books she wanted on psychology and philosophy. Now she has been sentenced to Kingston Penitentiary for two years and she wants to take the correspondence course in Welfare Services from the Ryerson Institute. I have written to the Commissioner of Penitentiaries, and the judge in the case has also written on her behalf, to see if they will allow the course material to go into the penitentiary and pay for it, as we can't afford it and she certainly hasn't any income. But if they don't come through we'll raise the money for her somehow.

Another example of a girl we have helped is a 23-year-old drug addict who came to Toronto about eight months ago. She has two children with the Protestant Children's Aid and we helped her get into the Adult Retraining Centre for a clerical course. She took this course for five months; I appeared in court for her with the Children's Aid, telling them what she was doing to get her children back. The two-year period for temporary wardship was almost up when she came to me, so they extended it for three months while she continued to go to school.

Hold off some more

A month ago I went to court with her again. Though she had finished her course, I didn't feel that she was ready to take the children — I was encouraging her to hold off another few months, which she did and which the judge was very co-operative about. Since that time she has become ill and is in hospital. Just before she went into hospital we had got her a job with Office Overload, and we will try to get her a permanent job when she is discharged. She wants to take her children back in the next month or so; I'm trying to encourage her to hold on to a job for at least six months or a year first.

This girl has also had her tattoos removed; she is about the fifteenth girl who has had this done through the Haven.

Lesbian relationships are one of the main problems we run into at the Haven; I would say that as many as 80 per cent of the girls are living or have lived in a lesbian relationship. All too often they come to us in pairs, and it's difficult to help one half of the pair because there's usually a lack of agreement and co-operation by the other half.

Would love to get out of it

I find they're very unhappy but very hostile to any suggestion of change or of getting professional help. It's usually the last thing I approach them about — hoping they'll approach me — because they're so mixed up and so afraid somebody's going to change them. Yet, deep down, I think they would love to get out of it. It's interesting at times to hear them say, unconsciously, "when I get married and have children" — but sit them down seriously and they'll swear up and down that they'd never go near a man.

The children of lesbians create another great problem; I would say that almost without exception the lesbians I see have borne children. Many of the girls are trying to keep their children; in other cases the children are in temporary care with the Children's Aid, or are living with the girls' rounder friends.

Many of the pregnancies are caused when the girls engage in prostitution without taking any care. On the other hand, many of the girls — butch and femme alike — set out to get pregnant, by marks or rounders, because they feel they want children; and of course they always want to keep the child. I try not to tell them definitely that I don't think they should; I just try to guide them, making them see all the problems they're going to come up against.

A child in the environment of a lesbian relationship is really unfortunate. There's a lot of jealousy; very often, if it's the femme's child, the butch half of the relationship might be compared to a jealous husband when the first baby is brought home. In a normal marriage there's a strong bond, but in this relation-

ship the other half can always use the threat that she can leave at any time.

The attitude of the girls towards men in the Haven is quite different now from what it was when I first opened. At that time the girls would just bristle when a man walked in, no matter who he was; now they feel differently about it and encourage them to come in. I didn't use to have the problem of rounder men coming in because, unfortunately, I didn't have that many straight girls there, but now I do; I'm very glad of that and I welcome their friends in as long as they keep the same rules as everybody else.

I've never been unaware of the problem of drugs being brought into the Haven. The girls found out very quickly that I wasn't very naive; just a few of them had to be frisked, and the news got around downtown, and they don't try it very often any more. Usually the only time I'll find goof-balls in a girl's pocket — or sometimes even a bottle — is when a girl is so high or drunk that she doesn't know she's got it on her; but very rarely do they try this deliberately, to the best of my knowledge, and I'm 99-per-cent sure that hard drugs have never been brought into the Haven.

I'm also aware of, and I clue my volunteers in on, the danger of connections being made over the telephone or right in the Haven. You can't be 100-per-cent sure that this won't happen, but we keep a pretty close watch for it — and also for girls' tricks phoning the Haven. The volunteers and I pretty well make a habit of answering the telephone and unless a man identifies himself satisfactorily we don't pass a call along to a girl.

No more stagnation

When I first opened, one of the problems I had was girls using the Haven as a flophouse; some girls would come and practically stagnate there. I wasn't unaware of it, but I was only one person and couldn't be everywhere, and the volunteers were new and didn't know what to do about it, so that a girl might be in and out of the Haven every day for two weeks without anything constructive being done for her. Now I have good experienced volunteers who can handle things like that on their own. I hear that the

word on the corners is "Don't go to the Haven or you'll get motivated onto something better." They don't use the word "motivated," but that's what they mean.

I have yet to bar a girl permanently from the Haven. If I think a girl is taking advantage — if it isn't just that she's not ready for help yet — then she's not allowed in for a certain length of time until she proves herself; and she doesn't usually try to come in during that time because she knows she's not welcome.

Weed themselves out

I have 45 volunteers now. They come from all walks of life — housewives, secretaries, office workers, nurses — and they all come totally unprepared. I'm very much aware of the do-gooder and the fanatic and the curiosity-seeker, but I find they usually weed themselves out pretty quickly; occasionally I've had to weed them out. Generally the volunteers are motivated by a basic caring for the girls, plus a lot of common sense. About 25 or 30 of them have been with me since I started and nothing would take them away now.

There's no set training program for the volunteers, although I think this might be a valuable thing and I hope perhaps to start one sometime. A new volunteer comes into the Haven either with me or with an experienced volunteer, to get the feel of the place and lose a little bit of the fear that she might have. I also take her to court to watch what goes on.

The volunteers involve themselves in every aspect of the Haven — the work with the girls, and the fund-raising. I have problems getting them to do secretarial work: many of them, when they first came, just wanted to do that, but as soon as they got at all involved with the girls they didn't want to do secretarial work any more. This is one of the big problems I have, trying to be administrator myself and still spend time with the girls, which I don't do as much as I would like to.

There are weekly volunteers' meetings over at Winchester Street which are well attended, and I encourage the volunteers to attend lectures and conferences. There's always a volunteer in court every morning and at drug court on Wednesday afternoons.

Typically, a volunteer may arrange to meet a girl at the Don or the Mercer on her discharge, go with her to the welfare office or the employment office, outfit her with clothes at Winchester Street and either help her find a place to stay or arrange for her to stay at Winchester if there's a bed available.

We often pay for a girl's lodging for a week or two when she first comes out of jail, because even if she gets a job the first day she's going to be a week or two without a pay-cheque, and the only way she can raise money is to go downtown to hustle. Once a girl has gone down to prostitute, you have lost the contact — temporarily, anyway.

About three times a week, one of us will be in the Don to visit girls — perhaps to take clothes to a girl for a court appearance or for transfer to Kingston. The head matron calls me quite frequently to see a girl for one reason or another.

I also visit the Mercer — not on a regular basis, but as the need arises. I can visit any girl on her request or on mine. Usually we try to visit a girl fairly quickly after her admission and just before her discharge or release, so that we can arrange whatever help the girl needs or wants.

I visit Kingston once a month, on my own or with volunteers, and we constantly write to the girls. We have about eighteen girls down there at the moment; this is a result of the drug roundup last September. At one time they referred to the girls as the Haven Alumnae, which didn't sound too good, but the reception is excellent down there now; they like the idea of what we're doing.

Love to have visitors

Visiting girls in hospitals is quite a job, too; right now I think we have seven girls in three different hospitals, so this takes up an afternoon. Often we have to arrange an appointment and accompany a girl to a clinic — hospital clinic, medical, surgical, or psychiatric — or visit girls in their homes if they are ill or tied down with children; they love to have visitors.

I'm starting street work with the volunteers now; I want to cover the Dundas-Jarvis area, Chinatown and Yorkville. I didn't

see the need for it before, nor did I have the time; I used to do it when I was working with the Sancta Maria House, but since opening the Haven I have had enough girls on my hands — I didn't have to go out and find any.

Down to the corners

But the volunteers themselves wanted to go down to the corners and see where the girls come from, and they have been pleasantly surprised because they are always greeted well by the girls down there; they all thought it wouldn't be this way. I remember I was surprised myself that the girls were always glad to see me and would introduce me to their friends, and sometimes I think it just takes going down into their territory to make it a little easier for them to come for help. If they know somebody up at the Haven, it might encourage them to come when they feel they're ready for it.

The volunteers also spend a lot of time picking up donations of furniture and clothes, and they do a lot of the secretarial work, and answering the phone and keeping the Haven clean and tidy. They go on emergency calls to hospitals and very often to the corners: we often get calls from places like (a restaurant near Dundas and Jarvis) saying "Please come and get So-and-so out of here before they pick her up;" — we usually go.

I've found that our relations with other agencies in the community have been very good — we've had very good co-operation. I think it took them a little while to get over the idea that I didn't know what I was doing. I've placed several girls with Elizabeth Fry, Sancta Maria House, the Homestead, and the Salvation Army emergency shelter.

"You can have her"

I've had excellent co-operation with the morality squad; more than once they have come up in a cruiser with a girl and said: "Well, you can have her, Peggy, or we'll take her," and of course I take her. They are very good; they know I don't hide a girl, and on the other hand they have never come to the Haven to pick up a girl on a warrant. The RCMP have been friendly with

me; they're non-committal and inclined to be sceptical, but neither have they come to the Haven to take a girl out, or raided the place or anything else.

Many of our girls are on probation. The probation officers often visit the girls in the Haven or call me about different matters concerning the girls, and I often go down to their office to talk to one of them about a girl. So far, we've been able to work very well together.

It costs us more than \$1,000 a month to run the Haven. The rent of the Haven is \$125; the quarter of the lease at Winchester Street is \$50; food runs anywhere from \$150 to \$200; my salary is \$400 and the expense on my Volkswagen averages \$50 a month. Then there are office supplies, carfare, a girl's rent payment now and then, and occasionally a fine. We don't make a habit of paying girls' fines, but if a girl gets picked up when she has been doing well, and we think paying her fine is justified, we occasionally do.

Sources of income

Until recently, our income came entirely from private donors. We now have a grant from your Foundation, a monthly grant from the United Church, a monthly donation from the T. Eaton Co., several smaller donations of about \$25 a month from private persons, and a dollar-a-month club. I think our donors have mostly learned about us from TV shows; I've been on TV about twelve times in the last year — four times with one or two of the girls and once with a volunteer — and on radio seven times. We've had excellent newspaper coverage: about fourteen feature articles in the daily papers in the last year and quite a few others in the smaller papers and magazines. We put out a brochure, which I think has brought in quite a few donations, and there's the newsletter as well. We also send out letters to corporations and companies, requesting funds and help. And there's the speaking to groups that I do; I speak, on an average, twice or three times a week, to Rotary and Kiwanis clubs, church groups and agencies like the Foundation.

Discussion

Q. Miss Walpole, is there any relationship between your group and the group that comes here for treatment?

A. Oh, yes, there are quite a few girls who use the clinic here, several as a result of our getting them in here. Also I have two who are living at Winchester Street right now who are patients here on methadone. And quite a few come to the alcoholism clinic, too.

Q. Another question I have is, what is your impression of what's taking place — you mentioned it earlier — of the Yorkville crowd moving in from the Village?

A. Well, I don't know that they're moving in, so much as that this problem is coming to us from the Village — girls who smoke marijuana and this type of thing that we didn't have until a few months ago.

Q. That's interesting, because as far as some of the Village residents are concerned, the rounders are moving the other way.

A. This could very well be; certainly the Dundas-Jarvis area is very dead at the moment; maybe this is where they all are.

Q. Your volunteers, Peggy — how much time would they invest? Is there a wide variance?

A. Well, I have two now who cover the five days a week — the daytime hours from 9 to 5, which is invaluable to me because they can take over completely. There are always two volunteers on duty in the Haven when it is open, and some give two or three mornings at court. The evening girls usually come just one night a week.

Q. The volunteers who cover the days, from 9 to 5 — are they housewives, or people with independent incomes?

A. They are housewives whose children are in school or university — who don't have to be home in the daytime.

Q. What is the average age of the girls at the Haven?

A. Probably around 23 or so. We have a bit of a problem with the young ones, under 16 even, coming to us. I always try to steer them out, but it isn't too easy. I'm always a little afraid of a young one who hasn't been around and who is just starting, making worse contacts in the Haven; but some girls who have come my way — 15-year-olds — when I try to steer them out, they won't do anything except go back to the corners; so we try to work through the Big Sister service, or try to get them to go back to their homes.

Q. As far as the Don is concerned, did you see any ways in which they could do more for the girls — more than is being done now?

A. Well, it's hard; I realize it's maximum security there, it's not meant to be a reformatory, but by the same token many of the girls spend six months or more there. The maximum sentence in the Don is 30 days, as you probably know, but they may have had some weeks' remand before that.

It's mainly the boredom, I think. There's nothing to do. A few of them work in the laundry, but this doesn't take very many girls — maybe half a dozen — and a few are allowed to scrub the corridors, if they're good. One thing the Haven did was to put a new library in. When I first went to the Don there was a total of 32 books and they were all very ancient. We got a couple of hundred books in.

Q. The women of Toronto have no way of exerting any pressure in this area?

A. I don't know; it certainly wouldn't do any harm.

Q. How do you feel about this experience of yours with the Haven?

A. I feel that we have had some very good successes. It's hard to measure lifetime success in only a year's operation, but many of the girls have taken significant steps towards rehabilitation — for example, the ones who are at Winchester Street right now, and taking responsibility in managing the house; girls who have hit bottom and are now organizing the baseball team; girls who have been holding jobs, good jobs, for six or seven months; girls who have got off drugs. An example, unfortunately, is this girl we are trying to get the correspondence course for in Kingston. She had been doing very well last summer. She had been withdrawn on methadone in ten days. She was taking definite steps towards rehabilitation when she was picked up on charges based on events months before.

Q. Miss Walpole, I presume that you are sometimes given as a reference when these girls are looking for employment. How much information would you give — how open would you be with a prospective employer?

A. Well, as open as I have to be, and that's all. I often tell the girls to give me as a reference just as a nurse, with my home address rather than the Haven address. I feel this gives them a better chance, and if a girl can hang on to her job on her own merit, why shouldn't she be given the chance?

Society and the Unlucky

There is nothing more expressive of a barbarous and stupid lack of culture than the half-unconscious attitude so many of us slip into, of taking for granted, when we see weak, neurotic, helpless, drifting, unhappy people, that it is by reason of some special merit in us or by reason of some especial favour towards us that the gods have given us an advantage over such persons. The more deeply sophisticated our culture is the more fully are we aware that these lamentable differences in good and bad fortune spring entirely from luck.

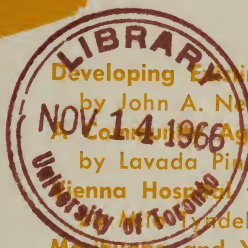
It is luck: luck in our heredity, luck in our environment, luck above all in our individual temperament, that makes the difference; and moreover at any moment fortune's erratic wheel may turn completely round and we ourselves may be hit by some totally unforeseen catastrophe. It is luck too, springing from some fortunate encounter, some incredible love-affair, some fragment of oracular wisdom in word or writing that has come our way, that launched us . . . on the stubborn resolution to be happy under all upshots and issues, which has been so vast a resource to us in fortifying our embattled spirit. At any moment we are liable, the toughest and strongest among us, to be sent howling to a suicidal collapse. It is all a matter of luck; and the more culture we have the more deeply do we resolve that in our relations with all the human failures and abjects and ne'er-do-wells of our world we shall feel nothing but plain, simple, humble reverence before the mystery of misfortune.

— John Cowper Powys: *The Meaning of Culture*
(New York: W. W. Norton & Co., Inc., 1929)

A.I.T. Addictions

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A.I.+ Addictions

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Developing Existing Services

by John A. Neilson, M.S.W.

The executive director of this Foundation, H. David Archibald, said in the annual report for last year:

"While we expect further growth in the patient load of the Foundation's own services, it should be stressed that the indefinite expansion of specialized clinical facilities is very far from our aim. Instead, we hope that the experience gained in our specialized clinical facilities will find its way into widespread use by all the healing professions and services throughout the province."

Well, why *aren't* we planning a large network of special services for alcoholics? Many professional people do proclaim their inability, or perhaps their unwillingness, to work with alcoholics, and often they suggest that special clinics, hospitals, recovery homes and so on are the only answers.

The overwhelming reason why a system of specialized facilities is unfeasible is that there simply aren't enough people to staff it. It has been said that to provide once-a-week contact with a psychiatrist and once-a-month contact with a social worker for all the alcoholics in California—some 800,000—

Mr. Neilson is director of the Eastern Ontario region of this Foundation. He gave this talk at the Foundation's fifth annual summer course at the University of Waterloo in June, 1966.

would require the full-time work of every psychiatrist and every social worker in the United States. I expect that considerably less care than this could be offered to Ontario's 100,000 alcoholics if the full-time work of all Canada's psychiatrists and social workers was available. I don't mean to suggest that only psychiatrists and social workers are appropriate treatment personnel. For example, Ontario has about 7,000 physicians, including general practitioners and specialists, both active and retired; each of them would have to expend 700 units of clinic time annually in order for every alcoholic in the province to be seen once a week.

Specialization makes waste

The second reason that makes specialization unfeasible is that it would result in an incredible waste. Many of the services required by alcoholics already exist in the community; or, if they do not, they may be introduced more economically through strengthening existing services. Why set up a special hospital for alcoholics when most communities already have hospital services, which, if not entirely adequate, at least have the structure for development to an adequate level?

A third reason that makes it seem preferable for alcoholics to be served by co-ordinated community health and welfare services is that special separate facilities would tend to isolate the alcoholic patient from the community. Separating the alcoholic from community care-giving services only reinforces the belief that he is very, very different from people with other kinds of problems. If you subscribe to the belief that, whenever possible, rehabilitation should occur within the community—as is reflected by the mental-health field in community mental hospitals and psychiatric units within general hospitals—then there is no reason why your belief should differ about the alcoholic.

Perhaps one of the most compelling reasons of all for the use of strengthened and co-ordinated community resources is that the alcoholic is already in contact with many of them. He is seen frequently at hospitals, at social agencies and at

municipal welfare departments. He presents problems for his employers and is a constant source of concern to the courts and the law-enforcement agencies. Of course, it is not always because he is seeking help that he is in contact with these services and institutions; but every contact nonetheless reflects his needs. Why not, then, use these points of contact to initiate help for him?

Massachusetts project

I was fortunate enough to spend September of last year with the State Division of Alcoholism in Massachusetts. A project planned and promoted by the Division, although not administered by it, exemplifies the co-ordinated use of community resources and, most important, illustrates how a program may be aimed at reaching detached persons where they exist in the community. Here is a description of the project:

The Skid-Row Centre administered by Boston University Medical School is a community-action program for unattached isolated non-alcoholics and alcoholics living in Boston's South End.

The South End is, by the way, Boston's main skid row. It originally was settled by the Irish but now is a catch-all for many ethnic groups. Many of the people living there have no resources, or extremely limited resources. Many live in isolation, on public welfare.

The centre is financed by the United States Office of Economic Opportunity and draws additional support from the Massachusetts Department of Public Health, the City of Boston and local health-and-welfare institutions. Through the services at the centre it is hoped that patients may find ways of making a more satisfactory adjustment for themselves and the community.

The centre's programs will be focussed into two services: direct work with patients, and on-going consultation to health, welfare and other appropriate resources. Direct service will include evaluation, referral to appropriate resources, co-ordinated community care, development of additional required community resources and pro-

vision of an on-going contact for all patients. The consultation service is geared to supporting, encouraging, and, through staff participation, discussing problems with those agencies that are involved with patients similar to those seen at the centre.

Men and women will be accepted for service if they fall within either of two groups: unattached persons who, in respect to the South End, may be established, transient or migratory, but for whom alcohol is not a problem; and isolated unattached persons for whom alcohol is a major problem. The centre's staff will consist of some professionals, some indigenous aids (i.e., residents of the South End hired to work in the centre) and volunteers. Case loads will be distributed so that no one carries only alcoholics or non-alcoholics. There will be considerable emphasis on reaching out, as it is believed that residents of the area will be suspicious of the centre—particularly at first.*

A recent letter from a friend of mine who works in the centre reads as follows:

"The centre is now going great guns. We are seeing about 100 cases per month and the lobby around the elevator at times resembles a well-run skid-row bar, even at times including the liquor. Some of our staff are using rental cars to seek out patients and bring them in to the centre. Then, depending on their needs, they move them around the community to obtain the services they require such as hospitalization, halfway houses, the Welfare Department, job counselling and so on."

Responsibilities of the special agency

The example presented by the South End Centre in Boston of a co-ordinated use of community services, and service initiated at the points where alcoholics are encountered, also suggests what may be the most appropriate responsibilities of the special alcoholism agency.

If you accept the proposition that many services for alcoholics may be provided through existing health and welfare and other community structures, then co-ordination becomes a vital

*From an unpublished article by a member of the project's staff.

concern. By co-ordination I mean the development of effective co-operation among all community resources that are, actually or potentially, of value in assisting the alcoholic.

Co-ordination

It is a fact that many organizations, public and private, are already involved in some area as part of this problem; but, because co-ordination is lacking, the work is often fragmentary and ineffective. I would like again to refer to Massachusetts to illustrate this point. In early 1964 a committee representing eleven state agencies, requested by the governor to examine costs and co-ordination, reported in part as follows:

The assessment of costs by various state agencies is estimated at approximately ten million dollars annually. This estimate is based on minimal expenditures and does not include the state Department of Public Welfare. Considering these factors, in all likelihood, the cost of alcoholism and alcohol-related problems by the state agencies is more likely in the vicinity of twelve million dollars yearly.

In addition to the cost of alcoholism in expenditures by state agencies, there is the cost of alcoholism in the state. The latter costs are not calculable at this time, but one can make an educated guess. There are many items that provide the basis for this guess which have not been included in the estimate of state agency expenditures. Among these items are: the arrest, booking, jailing and court processing (including probation) of the persons arrested for drunkenness; the legal and judicial procedures of non-support cases related to alcoholism; the city and county welfare, police, and judicial involvement; the private sector of medical services by physicians and hospitals; and the loss of wages and productivity in business and industry. These items, and many others, are tremendously costly and probably amount to at least twenty million dollars annually in Massachusetts because of alcoholism.

Combining the costs by the state agencies with the costs in the state, it is estimated that the cost of alcoholism and alcohol-related problems in Massachusetts is approximately thirty million dollars annually.

It should be made absolutely clear that the firm expenditure plus estimated costs, together totalling thirty million dollars, *are not being*

spent for constructive programs to combat alcoholism. Rather, the preponderant percentage of this money is being spent *because* of alcoholism. Arrest, incarceration, drying out patients, patching up bodies for alcohol-related disorders, picking up the pieces of disabled families, etc., although these are necessary, can by no means be equated with complete rehabilitative programs for alcoholics. Rehabilitation programs require a spectrum of services. . . . The main bulk of the money now being spent because of problem drinking is for containment, not rehabilitation.

In addition to co-ordination of existing services in order to overcome the fairly typical situation of fragmented services just described, it should be a primary responsibility of the specialized alcoholism agency to fill the gaps between services. This may be accomplished through grants of funds to existing services in order that they may be strengthened, or it may mean the establishment and administration of a service that is required and that cannot be provided in any other way. One example might be the establishment of special rehabilitation farms for chronic alcoholics who need a protective kind of care. At the same time, one must always inquire into the possibility of establishing such services under existing structures.

California farm

Take the example of a rehabilitation farm. Los Angeles County in California operates such a farm: Camp Acton. The people admitted to this service are unable to assume responsibility for themselves in the community, even though they receive public assistance. It is recognized that the bulk of these people are alcoholics, and there is a major emphasis on this area of behaviour in rehabilitation planning. In any event, where gaps in services exist and they cannot be provided due to the characteristics of community resources available, the responsibility to fill them should be assumed by the special agency. Education programs and demonstration treatment facilities fall within this category and should be provided by the special agency, which has an overview of all resources.

A third and major responsibility of the special agency is conducting and promoting research in all areas of the problem. I am not suggesting that the special agency do all of the research, since a great deal of it at the clinical and practical levels requires collaboration in order to make use of material and experiences collected by others.

Obstacles in the way

As you are no doubt aware by now, I subscribe very strongly to the development of services for alcohol problems out of existing services and structures. This is not the easiest view to hold, as there are many obstacles in its way. The kinds of obstacles one encounters are not necessarily related to the development of services for alcoholics. Mostly they are reflections of individuals and organizations, whether they are concerned about alcoholism or about any other problem.

In *More For The Mind*, or the Tyhurst Report, as it is called, there is a description of the clinical team. In a fairly elaborate fashion it lists the personnel required, the professional training they require and the roles they will play in team activity. Then there is one brief note as follows:

"It should be recognized that the functioning of the clinical team has aspects of function which can be understood by reference to contemporary knowledge concerning group processes and group dynamics. Such conceptions include references to group roles, the dynamics of leadership as an aspect of group structure, status relationships, methods of discussion and the like.

"Members of the clinical team should familiarize themselves with this type of information, because knowledge of group processes on a systematic level facilitates the function of clinical teams generally."*

The clinical team or any other kind of team should indeed familiarize itself with this type of information, since the failure to do so is at the bottom of many problems in professional inter-

*J. S. Tyhurst et al., *More for the Mind: A Study of Psychiatric Services in Canada* (Toronto: The Canadian Mental Health Association, 1963), p. 147.

dependence. The very formally organized team may be so rigidly structured that it really does not operate as a team. In some instances the team leader pays lip-service to shared responsibility, but gives it no real support. This kind of team often has the most defined roles, the most explicit procedures and the most regimented staff conferences. It is doubtful how much effective service it provides, since it is not designed for service but for the comfort of the team leader. The rigidly organized team tends to be more concerned with each member's role than with each member's capacity or potential. The team processes patients according to its own structure, rather than relating flexibly to their differing needs. The leader of this type of team never asks, "Which one of you feels he can do the best job with this patient?"; he assigns responsibility in a mechanical way.

Self-consuming entities

This type of team approach—clinical or otherwise—just festers along, with the members feeling more and more that their fellow team members do not understand or appreciate their job skills and enthusiasms. The hostility engendered may result in resistance, to the point where the team is of importance only to itself as a kind of self-consuming entity. It goes without saying that people cannot work effectively together if there is no organization. However, genuine professional interdependence is concerned with the service it provides, rather than the number of bodies it processes. It is concerned about helping people with their problems, rather than a dissection of their symptoms and the development of an administrative model for reassembly of the pieces. Interdependence is real when members of the team identify each other, not in terms of professional discipline, but in terms of inventiveness.

The structure of most community health-and-welfare services tends toward specialization. Services offered by each organization are supported by policies that determine the kinds and extent of services, and who shall be served. The title of the agency usually defines its general area of responsibility: family service bureau,

Children's Aid Society, mental health clinic, welfare department, general hospital and so on. While most such agencies do not say so in their policies, the majority of them offer some kind of service to alcoholics. Often this service is offered unwittingly: many agencies simply do not recognize either the alcoholic or the significance of alcoholism in family problems. For this last reason, or perhaps because policy tends to make it a low-priority problem, the help offered to the alcoholic may be fragmentary. Many of these difficulties can be overcome by education, the development of better communication between organizations, and so on. The real obstacles to working more effectively together arise out of the not-so-constructive ambitions of individuals and groups. Government agencies that are centrally administered sometimes fail to decentralize responsibilities into communities because they fear the loss of authority and independence that decentralization might bring. Separate government departments may openly compete for the opportunity to develop services, not because as individual departments they have special aptitudes, but in order to aggrandize themselves in terms of the boundaries of their authority. In one state I visited this past winter there was apparent open rivalry among the Division of Mental Hygiene, the Division of Public Health and the Department of Vocational Rehabilitation to obtain the state alcoholism program.

Vested interests

Another problem that often confronts one attempting to coordinate community services is that some agencies have a vested interest in the status quo. In some instances their area of concern, or their approach in service, has become obsolete. Other agencies have continued to amend policy, but in the direction of an even more careful selection of clientele. Some have readily adopted the rationalization that their services are only of value to the cleaner, better-paying middle-class citizen, and they restrict their services to this group. In San Francisco I attended a meeting of a Recovery Homes Association that included representatives from about eighty homes in the state. Their aim in developing an

association was to set up a central registry of clients in order that they might exclude non-paying guests from their services. Since most of these homes are self-supporting, it is not surprising that their managers should be concerned about funds. However, I was somewhat appalled that they had no interest in improving the services they offered, in view of the fact that recovery homes like these are nothing more than hostels offering bed and board.

Creating resistance

The representative of the special alcoholism agency, trying to co-ordinate community services in order that a comprehensive system may be developed, may step blindly into another obstacle—partly of his own making. He visits and talks with representatives of all the appropriate resources in a community, makes a list of all these resources, then sets them down in the form of some plan or model. Now, *he* may see this model as a solution to the community's problems in providing comprehensive care, but the community agencies may not see it this way at all.

When you approach an agency or a group of agencies, I think it's a very common experience that what you encounter first of all are the things that *these people* are concerned about—what *they* want to achieve; and if you go blithely along with your own personal desires, you may be extremely surprised that there is so much resistance to you—simply because you are not really appreciating them and their problems.

If the alcoholism co-ordinator's plan or model is used to stimulate thinking among community representatives, and not as a final solution, it may be of some value; but the real benefit the co-ordinator can bring to the community is perhaps first encouraging people to talk with one another and then, after they have had the chance to clear the air of their own concerns and grievances, helping them to begin consideration of what they in co-operation with others, may contribute in service to alcoholics.

A Community Agency and the Alcoholic

by Lavada Pinder, B.A.

For many years, community agencies have been aware of the effects of alcoholism on the people they served. Certainly, when cases have been assessed and the contributing factors sorted out, alcohol has often played a large part. One did not have to be too perceptive to see that the family roles became distorted; interaction was damaged; each family member felt misunderstood; normal social contacts were limited; meaningful goals, standards and values no longer prevailed; the children became confused; and the inadequacies of both marital partners became accentuated. However, in most instances, this type of assessment never went beyond the diagnostic stages.

Avoided the alcoholic

While I cannot speak for all social agencies, at least at Children's Aid Societies there seemed to be a marked tendency to leave the alcoholic member of the family alone. Well imbued with the principles of our profession, social workers did not judge the alcoholic; but, on the other hand, the casework relationship was seldom utilized on his behalf. We looked carefully at the strengths and weaknesses of the alcoholic's mate, in order to support and interpret; but we seldom looked at the entire family unit including the alcoholic member. The interrelatedness of the problem of alcoholism and the distortion of family relationships, often leading to family breakdown, were ignored. Occasionally a severe case would be referred to A.A. or for medical treatment; but, to be quite honest, this was usually in hope of a magic cure so that he could then re-enter the family

Mrs. Pinder has been on the staff of the Kingston Children's Aid Society for the last four years—the last two years as supervisor. This fall and winter she is completing work for her master's degree in social work at McGill. This article is adapted from a paper she presented to the annual conference of the Ontario Welfare Council in Toronto in May of this year, with additional material which she has supplied on "the case of Mr. T." Circumstances of the case have been disguised to prevent recognition of "Mr. T."

unit a changed, reformed person. These were classic examples of our lack of information concerning the alcoholic, whose drinking style is intrinsically linked to those whom he affects and by whom he is affected: his family.

Overcame fears

In 1961, the community consultant from the Alcoholism and Drug Addiction Research Foundation in Ottawa came to Kingston. For the past five years, the consultant has visited the probation office, the public health unit and our Children's Aid Society, and has established good communication with the local A.A. group. In working with our agency, he started at the point where we had become arrested, and began dealing with our fear of the alcoholic. In allaying this trepidation and mobilizing us towards treatment of the alcoholic, he has educated and informed us about alcohol. While most of us would still hesitate to define alcoholism, we look without timidity at what alcohol means to the person and how it interferes with his functioning and consequently with the functioning of his family unit. We have learned that there are phases through which the family of the alcoholic passes:

1. Refusal to admit that there is a drinking problem, and avoidance of all family problems;

2. Beginning of social isolation and of promises to reform;

3. The resulting state of family disorganization, when the children may become severely disturbed;

4. Role reversal, where the husband or wife takes over their partner's duties — it is usually at this stage that the family becomes acquainted with various social agencies;

5. Episodes of drunkenness are more frequent, and separation is threatened;

6. Separation, and the resulting reorganization of the family as a unit with the loss of mother or father figure; and, perhaps,

7. The alcoholism is arrested and adjustments must be made, as family difficulties can no longer be blamed on alcohol.

While one must be flexible in the use of these categories,

we have learned their value in recognizing the stage at which our agency enters a case; and the consequent planning is geared to this knowledge.

Most important has been our discovery of the facts surrounding a client's drinking habits. We no longer simply say he drinks a little, a lot, too much. The important factors are how much, what kind, when, where, how often, and what his own particular drinking pattern means in his family disfunctioning. It is only when we have explored this that we are in a position to be honest with the alcoholic about his reality situation. Permeating this approach is the gradual development of a trusting relationship. To reach out and indicate concern is not easy, for the alcoholic has usually turned to chemicals because he cannot rely on human beings.

Avoid immediate referral

In a Children's Aid Society, our awareness of the problem of alcoholism usually comes at the point where the children are becoming emotionally damaged or even physically deprived. The referral may come from a neighbour or a physician, or perhaps from the alcoholic's wife or husband who usually requests that we "straighten him or her out." There is a temptation to align oneself with this worried person, as she or he is usually seen as a tragic, brave, patient and helpless victim of circumstances; but, in essence, the non-alcoholic partner is usually implicitly or explicitly a participant in the difficulty. This is why the social worker must guard against immediate referral of the alcoholic partner in favour of the non-alcoholic partner and the children, with whom they usually feel more at ease. Once this conscious splitting of the family is accomplished, we end up with the multi-agency problem rather than the multi-problem family. Our responsibility is to the well-being of the children; and in concentrating on this area of child-rearing, the other areas of concern gradually reveal themselves. We try to make a referral to A.A. or some other resource only after a thorough assessment and after a child-centred relationship has been established, for

it is our feeling that immediate referrals can easily, and indeed justifiably, be interpreted as rejection.

In presenting cases to the community consultant from the Foundation, we have been continually reminded that the child-centred approach is a sound one. It comes very naturally into discussion of the needs of children and the needs of the parents and how they, themselves, were raised: when looking at the structure of the family as it stands, the social worker must also look into the early background of each parent, the quality of family relationships before alcohol became a problem, and the reaction of each member, including the children, to drinking.

In ten per cent of our present child-protection cases, alcohol can be considered a primary problem. It is obvious that one Children's Aid worker cannot be all things in each instance. However, I would like to stress that where the children are seriously affected within the meaning of the Child Welfare Act we feel a responsibility to maintain a continuing relationship with the family. We are fortunate in Kingston to have good medical and psychiatric facilities. The Ontario Hospital has an alcoholism unit, organized by Dr. George Laverty of Queen's University. Treatment at this unit is on a voluntary basis and involves both medication and therapy. Where we have been responsible for referral, we continue to work with the family; and they, in turn, refer to us when a patient's family needs help. This relationship is greatly assisted by the hospital's philosophy that the family is the alcoholic's chief motivation toward recovery and that when these ties are broken, rehabilitation is less likely.

Relations with A.A.

With regard to A.A. our roles are clearly defined. When A.A. realizes we are involved, the sponsoring A.A. members do not attempt to take over our job as child-protection workers; nor do we attempt to provide the social outlet and friendship that is unique in this organization. It is the practice in our protection department for new members to attend an A.A.

and Al-Anon meeting to familiarize themselves, before either referring or accompanying a client.

An example of community treatment wherein the Children's Aid Society remains the basic agency is that of Mr. T. Mr. T. came to the attention of the C.A.S. as a result of complete family fragmentation; and before our introduction to the treatment of an alcoholic, I'm sure the family would have remained permanently broken.

The case of Mr. T.

Mr. T. is 50 years old. He came to Canada from Europe with his father about 1930, attended school and finished part of high school. He remained with his father in Eastern Canada until 1939 when he joined the army. During an extended period overseas he built up an impressive military record, earning several medals. During the war he married a woman serving in the Women's Army Corps, but she was very shortly discharged for drinking and promiscuity. Marriage did not change this, and after a short period the couple was asked to leave army married quarters. Consequently, Mr. T. also left the army and came to Kingston, where he was hired by a local business firm.

After their marriage, Mrs. T. continued to drink and tested Mr. T. beyond his endurance by going out with other men. Mr. T. retaliated by drinking heavily and gradually began to rely on this escape. Totally unable to communicate, Mr. and Mrs. T. became bitter enemies—each intent on blaming the other for their unsuccessful marriage.

More positively, Mr. T. indicated stability within the paternal atmosphere of the organization where he worked—just as he had in the controlled atmosphere of the army. He remained at this job for eighteen years. When he began to have difficulty with his eyes and required surgery, he could rely on Workmen's Compensation and on the assurance that his job awaited him. Even when his alcoholism eventually lost him this job, his reliable work record enabled him to find other employment.

The children born to this marriage were two sons, now aged

17 and 14, and a daughter aged 10. Where his children were concerned, Mr. T's personal insecurity has been a deep and troublesome problem. Though he has no end of love and concern for the children, he has little understanding of their problems and feelings. Afraid to test their affection for him, he has given them little discipline.

Three-stage relationship

In reviewing our relationship with Mr. T., three plateaus seem to have been reached—each preceded by periods of time of varying lengths. First there was the period of initial contact, from March, 1961, to December, 1961. Both for our social worker, Mrs. A., and for Mr. T., this was an exploratory period, in which they developed a working relationship. It was in these early months that his children came into our care, and Mr. T. first admitted his alcoholism and found that the C.A.S. and A.A. were resources on which he could rely. Secondly there followed a two-year period of sobriety, from January, 1962, to January, 1964. This was a particularly satisfying time to Mr. T. and his friends: he worked steadily and rebuilt his home, and all three children were returned to his care. Also, although a different social worker became involved, the role of the C.A.S. became clearly defined. The third and present state began with a monumental drunk, but is largely one of levelling off and relative stability.

When Mrs. A. first met Mr. T., he was in the hospital recovering from an eye operation. The presenting problem was that of the three children left in the care of his wife, who was drinking and leaving them alone. While Mrs. A. went in immediately on the level of child care, it soon became evident that Mr. T's own uncontrolled drinking, even while in hospital, was a more basic difficulty. In rapid succession, Mrs. T. left the home and two of the children came into the care of our Society, the third being placed privately. With the family completely fragmented but the care of the children assured, Mrs. A. began to gather the facts about Mr. T's drinking.

Hospitalized a second time, Mr. T. became very unpopular with the hospital staff by getting drunk on the ward. Several times Mrs. A. attempted, quite unsuccessfully, to discuss Mr. T's drinking pattern with him. Each time he was able to rationalize that, because of his eye problem, he simply had a physical illness and took the odd drink. However, in May, 1961, Mr. T. was hospitalized on the psychiatric ward as an alcoholic and could no longer ignore this evidence. In consultation with the hospital staff it was decided that Mr. T. was an appropriate subject for intensive medical treatment geared to the alcoholic. Mrs. A. was selected to put the plan before Mr. T. She selected a direct approach: when Mr. T. attempted to say that drinking was not one of his problems, Mrs. A. said that in the five months she had visited him, she had never known him to pass up an opportunity to drink, and to her this indicated "a very big problem indeed." In the same direct fashion, Mrs. A. also pointed out to him that we had his children in our care and that as long as he was a drinking alcoholic, our agency would never return the children to him. But Mrs. A. once again reaffirmed that she would personally help him in any way she could.

A.A. comes in

One month later, Mr. T. was still sober and had started back to work; but six weeks later he was beginning to drink. By now Mrs. A. was a familiar figure to anyone concerned with Mr. T., and his landlady showed no hesitation in calling on her when he got drunk. It was at this point that she contacted A.A., with Mr. T's permission, and "Bill" came over immediately. Mrs. A. stayed to drink coffee, but was content to remain silent while the A.A. representative attempted to engage Mr. T. Important here is the fact that Mrs. A. recognized her limitations in trying to be all things to Mr. T. She realized his loneliness; having informed herself of A.A.'s method, she supported him in making friends within this group and encouraged his attendance at meetings.

Mr. T. was not immediately sold on A.A., and in the fall

of 1961 began to drink more and attend meetings less. Complicating this was Mr. T's growing dependence on the woman with whom he had placed one of his children on a private basis. This woman, quite sensibly, did not want to encourage this relationship; and she and Mrs. A. presented a solid, realistic front in this regard. Both reinforced Mr. T's connections with A.A., and by November the organization had become the centre and focal point of his life.

Throughout this period, Mrs. A. did not forget that Mr. T. was a father and that this was why she knew him. She constantly kept him in touch with his children's activities, and during his first six weeks of sobriety arranged for them to spend Christmas Day with him.

From December, 1961, until January, 1963, Mr. T. remained sober. His relationship with A.A., his good work record and his plans for the return of his children became the sources of his pride and self-respect. Despite the fact that he was once again hospitalized for eye surgery and his remaining child came into our care, Mr. T. did not resort to drinking.

The sons come back

This was also a rewarding period for Mrs. A., as she was able to settle into her more comfortable role of assisting in arrangements for the return of the children. She gave concrete help with budgeting, housing and the selection of a housekeeper. Since the discipline of his children had always been difficult for Mr. T., she could, within the newly serene atmosphere, discuss this realistically. Prior to the return of the two boys in August, 1962, she, Mr. T. and his housekeeper designed a household schedule suitable to adolescent boys.

Working with Mr. T. as an alcoholic was considerably narrowed. Occasionally Mr. T. would attempt to blame his wife both for his alcoholism and for the fact that his children were in care of our Society. It was at these moments that Mrs. A. would point out that while his wife had withdrawn as a parent, he had taken on the responsibility, and that he had been drunk

at the time the children had to be apprehended by the C.A.S.

Co-operation with A.A. became clearly defined. Mrs. A. expressed continuing interest in Mr. T's activities with this group and attended the occasional meeting, but in no way interfered. When Mr. T. had trouble with his housekeeper or discipline problems with the boys, and attempted to discuss this with his A.A. friends, they invariably suggested he talk over the whole situation with his social worker.

Miss B. takes over

Mrs. A. left our agency and her work was taken over by Miss B. who was able to follow with the approach set up by her predecessor. One of her first moves, and one which naturally endeared her to Mr. T., was to return his daughter. This was in March, 1963; shortly after this, the housekeeper left the home and Miss B. found she was able to reassure Mr. T. of his competence as a father.

Miss B. had read the agency file and became familiar with Mr. T's drinking pattern, but the actual experience of witnessing his fall off the wagon was frightening to her. She was personally aware of his successes, but not of his failures. To some degree she shared Mr. T's renewed self-doubts as she felt that the end of his two-year sobriety, in January, 1963, might somehow be due to her inability to follow through with the previous social worker's approach. However, she had little time to dwell on this as she was immediately called into the situation by Mr. T's eldest son.

Miss B. had never seen a crying, sick, remorseful alcoholic before, but it became immediately apparent to her that there was little she could say. Therefore, with Mr. T's consent, she called the top name on his list of A.A. friends. "Bill" from A.A. arrived almost instantly and told Mr. T. it was high time he "straightened up and showed some guts." To Miss B., whose first instinct had been to offer as much sympathy as possible, this approach was foreign; yet as the harangue continued she could see Mr. T's shoulders begin to square.

This drinking bout had been precipitated by the threat of another operation on his eye, by financial worries, and by the fact that there was no one to look after the younger child. He continued to drink, went into hospital for surgery, and took up his drinking again when he left hospital—despite continued effort on the part of Miss B. and his A.A. friends. Finally, called in when Mr. T. had reached bottom and was too depressed even to cry, Miss B. firmly suggested that he sign himself into the Ontario Hospital for 30 days. Dried out, he was proud of the fact that he had taken this step and once again the building process began. This time Mr. T. was without a job, for during one of his recent lapses from sobriety he had become angry and announced to his boss that he was quitting. Refusing to reconsider even after 18 years of employment, the firm took him at his word. This was discouraging; but Mr. T., after his relapse, was starting on firmer ground than ever before. He had his home, his children, and good relationships with Miss B. and A.A. His reliable work record helped a great deal and he is now working at a permanent position as night watchman in a local plant.

C.A.S. gained knowledge

This case is a usual one from the point of view of the alcoholic's cycle, but unusual from the point of view of involvement by a Children's Aid Society. What we have gained is the knowledge that persistence is rewarding—that even with recurring alcohol problems, the alcoholic can be helped: even with the occasional "slip," there are enough steps forward during periods of sobriety to make progress ongoing.

Both of the social workers in this case—Mrs. A. and Miss B.—came to our Children's Aid Society when they were in their early 20's. While they may have lacked experience, this was counteracted by enthusiasm and determination. Even more important, they were somehow able to absorb the disappointments and still doggedly carry on. Many professional people more experienced in work with alcoholics, particularly medical

personnel, offered little but discouragement. Typical of this was the doctor who told Mrs. A. in the early stages of her contact that Mr. T. lacked the intelligence, insight and real desire to be helped.

Other gains

While I have dealt exclusively with alcohol problems as related to child protection, there are several other ways in which a knowledge of alcoholism has increased our casework service. For example, when an adopting applicant has or has had a drinking problem, we know what he is talking about. When a teen-age ward goes on probation because of drinking under age, we are in a better position to use authority to make his offence more meaningful to him. The other day when a young man who had been a ward of our agency came back to talk about his family, saying that he had heard his mother had been a dreadful drunk and this is why he had been taken away from her, we were better able to explain his mother's problem to him.

In our admittedly short time working with alcoholics, several factors emerge. We have learned that a persistent, concerned and realistic relationship can be developed within which the strengths of the alcoholic will be encouraged. We have learned to treat the alcoholic in relation to the people he cares most about: his family. We have learned not to give casual referrals just to get the alcoholic out of our hair. And, we have learned that community awareness leads to defining roles and away from overlapping, and multi-agency problems.

Change of Address

The Head Office and the Education Division of this Foundation will move to 344 Bloor Street West, Toronto 4, in November. This address will replace 24 Harbord Street as the mailing address for all departments of the Foundation.

Vienna Hospital for Alcoholics

by Milo Tyndel, M.D., Ph.D., F.A.P.A.

The first institution in Austria dedicated exclusively to the treatment of alcoholics, the Genesungsheim Kalksburg (Kalksburg Convalescent Home), was established in Kalksburg, a suburb of Vienna, in 1961. Prior to that year, alcoholics in need of hospitalization were admitted to psychiatric hospitals. The Kalksburg hospital has unique features, particularly in the extent of patient participation in its development and functioning, which may be interesting to persons elsewhere who are concerned with the rehabilitation of alcoholics.

It was conceived as a hospital for persons with drinking problems, mainly in the sense of excessive consumption of alcohol due to psychological disturbances, and also for chronic alcoholics, meaning those who had suffered physical, psychological and social damage due to excessive drinking. From the start, the admitting policy emphasized the voluntary admission of persons requesting hospitalization on their own determination or on the advice of physicians and other members of the helping professions. Early detection and treatment was regarded as the mainstay in the fight against this disease. Various therapeutic methods were planned, but occupational therapy was encouraged as one of the most significant means of rehabilitating and re-socializing alcoholics.

I visited the hospital in 1963 at the invitation of its chairman, Dr. Hans Hoff, who was my teacher and scientific supervisor in Vienna and with whom I have maintained a close research contact during the years of my work for the Alcoholism and Drug Addiction Research Foundation in Toronto. I paid a second visit in May of this year, and was pleasantly surprised by the progress I observed. After five years of operation, the work of the hospital has more than lived up to its original expecta-

Dr. Tyndel is research psychiatrist at the Foundation's central Toronto clinic and a research associate in the University of Toronto Department of Medicine.

tions, mainly due to the devotion of a group of professional people headed by Dr. Hoff, who is also the professor and chairman of the Department of Neuropsychiatry of the University of Vienna and a member of the Supreme Health Council of Austria. Dr. Hoff has distinguished himself as a teacher, researcher and writer in most areas of neurology and psychiatry and is considered the founder of the "new school" of neuropsychiatry, which combines the great Vienna tradition with the modern achievements and methods. He is particularly interested in the social aspects of psychiatry and has focused scientific and public attention on the long-neglected area of alcoholism.

The fact that the head of the university department and the head of the hospital for alcoholics are the same person seems to be valuable in giving the hospital the necessary prestige, weight and scientific ambition in its planning and work. The hospital's director, Dr. Kornelius Kryspin-Exner, is one of Dr. Hoff's university assistants. The hospital now employs five psychiatrists, two occupational therapists, five nurses and two social workers; one of the social workers is associated with the mental hygiene organization; the other is associated with the city government, establishing a close liaison with the city health services.

Enlargement in progress

The building was donated to the hospital by the Workmen's Pension Institute; the funds for its reconstruction, refurbishing and operation were raised through donations from various bodies. During the years of operation, adjoining lots were purchased; the grounds now cover 22,000 square metres, and additions to the building are being constructed that will add 25 rooms to the present 30. The enlargement of the hospital calls for 120 beds instead of the 63 now available. The beds are occupied at all times, but the waiting lists are not excessively long—usually not longer than a few days. The rooms accommodate one, two or three patients. The patients' rooms, the dining hall and other facilities are spacious and bright, and tend to provide an atmosphere somewhere between a private home

and a hospital. An out-patient clinic for the after-care of discharged patients is kept busy at the rate of 4,000 visits a year.

Treatment is carried out chiefly in groups of fifteen to twenty patients, partly with psychodynamic orientation. Drug therapy is used to a lesser extent. Most emphasis is laid on occupational and industrial therapy in the sense of the patient's utmost participation in operating the hospital and improving and enlarging its facilities.

Patients take part

With understandable pride, the visitors are shown a laundry room, garage, swimming pool, miniature golf course, intercom system and furniture built by groups of patients, among whom are professional persons—for example, engineers, who are responsible for designs and supervision. The porter, the receptionist and the persons in charge of the laundry, tools and the like are patients, and the services are run with a minimum of friction. The food is nourishing and tasty. The patients make their own refreshment drink, a non-alcoholic apple cider which seems to be the equivalent of the coffee customarily offered in similar places on this side of the ocean.

The results of treatment are encouraging both in abstinence and in social rehabilitation; for example in 1963 the reported rate of abstinence and social rehabilitation was over 44 per cent, and that of social rehabilitation with one or more short relapses was over 24 per cent. These results need some qualification, as the selection for admission is fairly strict: psychotic patients and those with extreme social degeneration are excluded. On the other hand, a fairly large number of patients with a history of delirium tremens were admitted for treatment and follow-up.

There is close co-operation with the Vienna Sick Fund for workers and employees. This fund is the biggest state and city insurance carrier, covering the vast majority of the working population and their dependents; it is sustained by compulsory contributions from employers and employees, and by government

subsidies. The insurance carrier defrays the expenses of the patient's hospitalization. There is also close co-operation with the employment offices of the city and of the province, facilitating treatment and social rehabilitation. For understandable reasons, the insurance carrier is interested in the patient's recovery and return to gainful occupation. The patient's discharge from the hospital stops payment of hospitalization expenses and benefits for his dependents, while his return to work automatically entails resumption of contributions to the Sick Fund. From the viewpoint of the insurance carrier, patients discharged from this hospital do not seem to fare any worse than the insured among the general population as far as reinstatement in gainful occupation is concerned.

The hospital develops and carries out alcoholism research and education programs in co-operation with the university and with a number of city and provincial agencies, as well as with private organizations.

Principles of treatment

The principles on which treatment at the Genesungsheim Kalksburg is based are not new—they are applied in other treatment centres of alcoholics throughout the world; but they are not often realized to the same extent as at Kalksburg. Among these features, I would emphasize the following: firstly, the basic principle of voluntary admission, secondly, participation by the patient to the greatest extent possible in the construction, development, maintenance and operation of the hospital; thirdly, close association of the hospital with a university department of neuropsychiatry and close co-operation with the insurance carrier, the unemployment services and a number of both government and private agencies; finally, the pleasant atmosphere which, together with the work program, helps patients avoid both the stigma of being in a psychiatric hospital and the stigma of being an alcoholic.

Marihuana and Young Adults

— a preliminary report

by Ingeborg Paulus, M.A., and Hugh R. Williams, B.Sc., M.D.

This preliminary report on a study investigating the use of marihuana and other mood-changing drugs by young adults in Greater Vancouver employs no theoretical framework, but seeks to set forth some of the facts consolidated at this point.

The inquiry was prompted by a concern about the increasing use of marihuana and the consequences this use might engender. The Narcotic Addiction Foundation of British Columbia is, of course, concerned, whether or not the use of marihuana in Vancouver might eventually lead to the use of heroin. The pattern up to this time has been that heroin addicts started their road to addiction via alcohol or barbiturates or both. Many have used heroin as a first drug. Only rarely did we see a patient who had smoked marihuana previous to the use of heroin. However, from what we know, the pattern in the United States has been different, and often marihuana smoking preceded heroin use.

Obtained from hemp

The drug known as marihuana in North America is obtained from the flowering tops of the female plant of *Cannabis Sativa*. In other countries it is known as *hashish*, *bhang*, *charas* or *kif*, and varies in composition and strength according to cultural preferences. The hemp plant will grow in any temperate climate, but thrives best in warm ones, such as in the Far and Middle East, Mexico (major source of West Coast marihuana) and the southern United States. The resin of the flower contains the most active principle of the drug, which acts on the central nervous system.

Miss Paulus is research associate and Dr. Williams is clinical director at the Narcotic Addiction Foundation of British Columbia, 2524 Cypress Street, Vancouver 9. This paper first appeared in the *British Columbia Medical Journal* (Volume 8, Number 6, June, 1966) and is reprinted here, slightly abridged, with permission of the Journal and the N.A.F.

In North America the top of the flowering plant is cut, dried, chopped and used in marihuana cigarettes. Among other names, these are referred to as reefers, sticks or joints. The color ranges from light green to dark brown, the texture from coarsely cut leaves, stems and seeds to a fine powder.

Effects vary

Until further North American experimental data are available, the Goodman and Gilman description of the effects of marihuana seem to resemble most closely those reported by the young adults questioned:

The subjective effects of the drug are exquisitely dependent not only on the personality of the user but also on the dose, the route of administration, and the specific circumstances in which the drug is used. The most common reaction is the development of a dreamy state of altered consciousness in which ideas seem disconnected, uncontrollable, and freely flowing. Ideas come in disrupted sequences, things long forgotten are remembered, and others well known cannot be recalled. Perception is disturbed, minutes seem to be hours, and seconds seem to be minutes; space may be broadened, and near objects may appear far distant. When larger doses are used, extremely vivid hallucinations may be experienced; these are often pleasant, but their coloring, sexual or otherwise, is more related to the user's personality than to specific drug effects. There are often marked alterations of mood; most characteristically there is a feeling of extreme well-being, exaltation, excitement, and inner joyousness (described as being "high"). Uncontrollable laughter and hilarity at minimal stimuli are common. This is often followed by a moody reverie, but occasionally the depressed mood may be the initial and predominant reaction. With the larger doses, panic states and fear of death have been observed; the body image may seem distorted; the head often feels swollen and the extremities seem heavy. Illusions are not uncommon, and the feeling of being a dual personality may occur. Even with the smaller doses, behavior is impulsive and random ideas are quickly translated into speech; violent or aggressive behavior, however, is infrequent. When the subject is alone, he is inclined to be quiet and

drowsy; when in company, garrulousness and hilarity are the usual picture. Given the properly predisposed personality and high enough dosage, the clinical picture may be that of a toxic psychosis. In studies on cases of prolonged use, subjects became indolent and non-productive and showed neglect of personal hygiene; they quickly lost interest in both assigned vocational tasks and recreational pursuits.*

The Western literature indicates that marihuana is not addiction-producing with the twin signs of tolerance and physical dependence so characteristic of opiate addiction. There is no confirmed evidence as yet whether it produces psychological dependence or simply a habit, perhaps hard to break once well established. Despite the claims of marihuana smokers that they can voluntarily discontinue use at any time without experiencing undue suffering or craving, confirmed users bitterly resent deprivation and readily admit their intention to return to the drug as soon as conditions permit.

Under Canadian law, marihuana is classified as a narcotic. It was placed on the Opium and Narcotic Drug Act in 1923. (In the United States, it was not federally controlled until 1937.) As a narcotic, marihuana comes under the jurisdiction of the narcotic regulatory bodies of the United Nations, having been brought under the same restrictions as the opiates and cocaine in the Geneva Drug Conventions.

Seven years for possession

Under the provisions of the Narcotic Control Act, 1961, every person is guilty of an indictable offence and liable to imprisonment for up to seven years if convicted of possessing or cultivating marihuana, and liable to imprisonment up to life if convicted of trafficking.

We now ask the question: Who are the persons who smoke marihuana, knowing that conviction under the Narcotic Control Act carries such severe penalties?

*Louis S. Goodman and Alfred Gilman, *The Pharmacological Basis of Therapeutics* (3rd ed.; New York: The Macmillan Co., 1965), p. 300.

The data make no claim to be representative, but from fifty questionnaires, twenty substantiated with personal interviews, the following has been learned so far:

The age range of the sample consisting of 38 males and 12 females was from 17 to 34. The average age of the males was 23½, of the females 22; average education for the males was 12½ years, for the females 13 years. Eight were or had been art school students; 15 had a part university education or had completed a B.A. Thirty-one were single; the others were legally or common law married, with a few of them separated or divorced. Although many were single, this did not mean that they were necessarily living alone or with friends of the same sex. Only 11 of them had always lived in Vancouver; the others moved to Vancouver as recently as a few months ago.

Many not employed

Twenty-nine (66 per cent of the females and 55 per cent of the males) were employed either part-time or full-time in a variety of occupations ranging from cook, cab-driver, car washer, waitress, or clerk to teacher, manager, shop-owner or artist. Some were students being supported by parents or living on savings, and a few of the unemployed were "state-supported." The unemployed were those with the fewest years of schooling. Many gave their professions as "artists," but since they were unable to support themselves by their artistic endeavours, they or their "spouses" held temporary jobs to meet their daily living demands. These, for many, were few and bordered on subsistence living. Ten had children to support.

The average number of marihuana smokers each respondent knew personally in Vancouver was about 80, with their average age ranging between 18 and 25. Only a few mentioned knowing "pot-heads" over 30. In other words, marihuana smoking in Vancouver could be classified as a "young adult's activity." These young people are not afraid to experiment with mood-changing drugs: the majority have used LSD and many have tried other drugs including morning glory seeds, peyote, Romilar, ampheta-

mines, barbiturates and narcotics. But only a few have tried heroin, and most of them claim to despise the "junkie" and what he stands for.

The precise effects of the drug sold as marihuana in Vancouver are difficult to determine. Experience under the drug often varies from person to person. It also varies with the frequency and quantities ingested.

Generally smoked

In Canada in general, and in Greater Vancouver in particular, the drug is generally smoked. The smoke is inhaled together with air so that the intoxicating resin of the *Cannabis Sativa* plant enters the bloodstream directly from the lungs. Admitted immediate effects include euphoria, exhilaration, giddiness, uncontrolled laughter, dreamy states, loss of inhibitions, heightened perceptions and a changed sense of time. They may be accompanied by an unpleasant dry throat, hacking cough, nausea or even a headache. Generally, the admitted effects are more pleasant than unpleasant, and no hangover is experienced.

Marihuana in Vancouver is mainly smoked for kicks, pleasure, escape or the psychedelic effects this drug offers. It rarely produces violent reactions, but this may depend more on the people who smoke it than on the drug.

Not many respondents reported adverse reactions while under the influence of the drug. But this may be understating the dangers, since they definitely have a vested interest to see the tight controls loosened. They admit that it may have harmful social effects if abused, as for instance being instrumental in traffic accidents by those who drive while intoxicated by the drug. Fortunately, few own or drive cars. The most often reported detrimental effect seems to be "paranoia," often caused by fear of being detected by the law.

Many resent the fact that marihuana, though not a narcotic, is controlled under the Narcotic Control Act. About half would not want to see marihuana sold like cigarettes, but advocated some type of control. However, they insist that it should be

available for pleasure, conviviality, psychedelic experiences or escape in the same way alcohol is. They are quick to point out that marihuana is far less dangerous, both physically and socially, than alcohol. And they speak from experience, for many of them had been drinking excessively at one time or another but cut their alcohol intake considerably when they were introduced to marihuana.

There is no doubt that smoking marihuana is a "contagious disease;" and its advocates are great proselytizers. Marihuana smoking in Greater Vancouver became *en vogue* about eight years ago among a small group of aspiring artists. From there it spread, slowly at first and then rapidly, among Vancouver's young "hippies" and "beatniks." With the growing popularity of Vancouver among a "wandering" young people, especially from Eastern Canada, marihuana smoking suddenly hit the news as a "problem" during the past two years.

As far as can be discerned, it seems to flourish among five distinct groups; some of them overlap but others don't. There seems to be only one group that operates on the fringes of society and it is mainly composed of a "rounder" or criminal element. No details are as yet available about this group, except that they exist and have little in common with the others, who are "unconventional" in many respects but nevertheless, except for smoking marihuana, are fairly law-abiding citizens.

A pleasant pastime

For many of them, marihuana smoking will be just a passing fad, and part of that kind of experimentation which seems necessary as a form of rebellion against authority. For others, no doubt, marihuana will always remain a pleasant pastime—something to be indulged in when time and money permit. For others still, it will become a crutch, if it is not already; and when it is not available, other drugs or alcohol will be used instead.

Many of these young people at times drank heavily. They moderated their drinking once they started to smoke marihuana. They feel that they have made a socially and physically wise

choice. Since they rely to a large extent on their own and their peers' judgments, they consequently deplore the "hypocritical attitudes of the Establishment," which allows free access to the relatively harmful drug alcohol but severely restricts the use of the—in their opinion—relatively harmless drug marihuana.

Search for identity

The general impressions gained from interviews and questionnaires so far are that many of the younger marihuana smokers are young adults who say they are in search of an identity which the allowed modes of expression in a conformist, materialistic society seem to deny them. Others come from the kinds of background (broken homes, unfit parents, lack of parental concern) which endanger personality development. Others are simply looking for kicks.

From our data, it seems that most of the "pot-heads" in Vancouver have very little in common with the heroin addict the NAF sees as a patient. Furthermore, it seems reasonable to assume that only a small number of those so far investigated will become "social problems" in the true sense of the word. Some might become psychologically conditioned to the use of the drug and might "crave" it when it is not available, but few would commit serious criminal offences, other than buying, selling and possessing it, in order to maintain a steady supply.

To be sure, their attitudes towards work, love, sex and play are somewhat different from those of society. That some of these young people seek to substitute a drug-using clique for healthy family interaction seems one of the more deplorable aspects of this "rebellion via marihuana."

What the exact physical consequences of the drug are when tested on a variety of people over a period of time can only be ascertained by scientific experiments. These, for the present, are restricted. The authorities concerned feel that the dangers of the drug have been sufficiently proven and that no further tests need be carried out. But the young people who try the drug and do not experience any or many of the stated dangers are all the more

eager to disprove commonly-circulated "facts." Some of them are paying heavy penalties for this experimentation.

Marihuana smokers, unlike heroin addicts, are not likely to appear as "patients" in doctors' offices needing withdrawal from drugs. When no marihuana is available, they do not suffer withdrawal symptoms. Some never buy marihuana and consequently smoke it infrequently. Others buy and sell it and use it quite frequently. But any medical or psychiatric help they might need will not be different from that of the population at large, except that this group seems to contain a larger share of the population who could benefit from psychiatric help. Lack of knowledge, lack of money and lack of general concern seem to drive some of them into a "mutual aid society" where, with the help of drugs, many become their own "therapists."

Skid-Row Medical Study

A paper that is part of a study by this Foundation was published in the July 30 issue of The Canadian Medical Association Journal. It is entitled "*Skid Row*" Syndrome: A Medical Profile of the Chronic Drunkenness Offender, and is written by Dr. Jack S. Olin of the University of Toronto Department of Medicine. Dr. Olin was medical research associate for the Foundation's study of the C.D.O.

The paper reports the findings of a team made up of social workers, psychologists, a psychiatrist and a specialist in internal medicine (Dr. Olin). The team studied 227 chronic drunkenness offenders who were inmates of the Toronto Jail, to determine their physical features and illnesses. They carried out complete physical examinations, liver function tests, routine hematology, urinalysis and chest radiographs and obtained the previous hospital records of each man.

On an average, the men in the sample were forty-five years

old, had been drinking heavily for twenty years and had four drunkenness convictions a year. The team found that 8.8 per cent of the sample had tuberculosis, 8 per cent had epilepsy, 3 per cent had definite cirrhosis of the liver, 75 per cent were under the Canadian average weight, and 25 per cent had significant body deformities.

The team estimated that if necessary therapy was carried out, ninety per cent of the sample would be able to perform useful work.

The team considered that the high incidence of tuberculosis among the skid-row drinkers was the most important finding of the study. Dr. Olin and Dr. Stefan Grzybowski, who then was with the Ontario Department of Health, published a separate paper on this subject as a sub-study. The paper was called *Tuberculosis and Alcoholism* and appeared in the May 7 issue of the *C.M.A.J.*

Reprints of both papers are available from the Education Division of the Foundation at the address on the inside front cover of this magazine.

New Play about Alcoholism

— *Lady on the Rocks*

Delegates to the annual conference of the (United States) National Council on Alcoholism, Inc., in New York last April saw the premiere of a new play about alcoholism: *Lady on the Rocks*, by Elizabeth Blake.

Commissioned by the NCA, the play is a production of Plays for Living, a division of the non-profit Family Service Association of America. The NCA says the play is intended to involve the public in discussion of alcohol problems and to promote a help-

ful attitude towards alcoholics. Inquiries about the play should be addressed to the NCA at 2 East 103rd Street, New York, N.Y. 10029.

With a cast of four, "Lady on the Rocks" dramatizes a woman's final realization that she has an alcohol problem as she tells her story to an interviewer at an alcoholism information centre. Her narration links flashback scenes in which she acts out key incidents of her drinking history with her husband, her fifteen-year-old son Danny, and his girl friend Sue.

Hears children talk

In the climactic scene, the woman overhears a conversation between Danny and Sue, whose father is an alcoholic and who is a member of Ala-Teen, an organization for the children of alcoholics. She learns from the conversation that both Sue and Danny are aware that she has an alcohol problem, and her humiliation drives her to seek help.

The excerpt below contains the last part of this scene, with Danny talking to Sue as his mother listens:

DANNY: *Who's worried? Who cares? It's funny to me . . . that's all! . . . It's funny! . . . Like some crazy old junky merry-go-round that keeps goin' on and on . . . just gettin' nowhere! Like last night. Man, you shoulda' been here. We had that "Why-can't-you-live-within-your-budget-I'm-no-millionaire" jazz!*

SUE: *(Smiles and imitates a man's deep voice.)* No wonder we can't afford to take a vacation like other people!

DANNY: *(Laughs.)* Yeah, that's it. *(Imitates his mother's voice, exaggerating her tipsiness, as she reaches for a glass.)* Vacation! Where would we go? *(Hiccup.)* To some special underwater resort . . . Restricted—For Halibut Only! *(SUE bursts into giggles.)* Or we might find some secret cave in the Australian desert where only the natives would know. *(Hiccups again and continues superciliously.)* I certainly wouldn't

want to embarrass you in front of your friends. They're so proper!

SUE (*in her deepest voice*): At least they're sober. They know when to stop . . . like any *sane* person.

DANNY (*himself again*): He blew his stack about the car, too.

SUE: Did he take the keys?

DANNY: I almost wish he had.

SUE: Mom took Dad's keys away once.

DANNY: She did? Gee, maybe I should hide ours.

SUE: Mom was so scared she even used to drive him to A.A. meetings . . . the first couple of times anyway . . . just in case he slipped.

DANNY (*imitating his mother's voice again*): I've never had a ticket in my life. (*Almost to himself:*) And she hasn't.

SUE (*imitating his father*): You're not responsible any more. . . . You're not fit to drive!

DANNY (*in his mother's voice*): I have never even bumped a fender! That's more than you can say! I am an excellent driver! (*He gestures drunkenly, wildly, as if to a group.*) Come on, kids . . . pile in! (*He pretends to be driving, swerving from one side to another. He is now like a child overcome by his own game. He imitates the sound of the motor.*) Brrrrr. Brrrrr. Brrrrr.

SUE: (*Watches him quietly, but as he continues it becomes too painful for her. He turns back, starts to run into her and she jumps to one side and tries to stop him. Her voice is soft and full of compassion.*) Oh, Danny . . . Danny, don't do that to yourself. Danny, stop. She's just like Daddy. Don't you understand? (*Louder:*) Danny . . . face it . . . your mother's a drunk, too!

DANNY: (*Stops and suddenly freezes in violent anger. He lifts his hand as if to strike her, but stops himself. Shouts:*)



—photograph by The New York Times

Don't you say that! (*Dropping almost to a whisper:*) Don't you ever say that again! It's not . . . (*His voice breaks and he turns his back to hide his tears. There is a moment of silence. Then SUE starts to cry, too.*)

SUE (*quietly*): Danny . . . please don't. Danny . . . I . . . I know how you hurt inside. I did, too . . . but it's so much easier if . . . when . . . you don't have to lie about it. It's not a disgrace . . . it's a disease! (*She starts towards him.*)

DANNY: Leave me alone.

SUE: I know it's hard to figure, but some people *can* drink and some people can't, that's all. She's hung up on alcohol. It's a disease, like heart trouble or diabetes.

DANNY: (*Keeping his back turned, runs off stage.*) Go away, I told you.

SUE: (*Follows, still pleading.*) Danny . . . Danny, please listen . . . It can be treated! It isn't hopeless!

The Church as Therapist

— help or hindrance?

by Rev. Donald F. Collier, B.A., B.D.

When the title of this address was first suggested to me it made me feel uncomfortable: any clergyman dislikes thinking of the Church as a hindrance to therapy. But I could not deny that the title posed a real question. In one of our clinic's therapy groups, a patient who had ignored my presence for a number of meetings suddenly looked the group leader in the eye and asked, "What possible justification is there for a theologian being here?" I was flattered at being called a theologian; but much more, I was troubled by the question, because I had been asking the same thing myself. Interviews with patients had revealed to me that in their experience the Church frequently had been of no positive help and often had been quite negative in its relationship to them. There was good reason for doubting the value of the Church's role in therapy for the problem drinker.

Since then I have gone ahead in faith with my work, clinging to the belief that the Church does have help to offer with the problem of alcoholism. This address is the beginning of an attempt to work out the content of that help and to suggest ways in which the Church may make it available.

Three areas of failure

I begin, as a churchman, with confession and offer what admittedly is an over-simplified analysis of the Church's failure in its ministry to the over-drinker. I see three major areas of failure: in the Church's judgmental attitude, in its abdication of responsibility towards the over-drinker, and in its attitude to "the normal use of alcohol."

I know that sermons are still preached against the Demon

Mr. Collier is the director of the Foundation's new rural rehabilitation unit at Elora, scheduled to open this fall. He was the pastoral counsellor at the Foundation's East Toronto clinic. He delivered this address to a symposium on alcoholism sponsored by the New Brunswick Department of Health at Moncton in October, 1965.

Rum and the sin of drunkenness, much as they were during the nineteenth century. Many preachers are very proficient at chastising the over-drinkers. They do it so well that they drive them right out of the Church. I heard one clergyman say that in his denomination they did not have much of a problem with over-drinkers because his church took such a firm stand against drinking. What that man could not see was that, however kind his intentions, people with drinking problems did not go to his church—because they believed they would be received unsympathetically. I remember a patient who had been raised in that same denomination telling me of the night when he was asked to leave the church because he had the smell of alcohol on his breath. He left, all right, with a genuine regret and longing; and he has not been able to return.

Preaching won't work

I believe that drunkenness is a sin, as are all forms of excess and intemperance. But we have to distinguish between the man who gets drunk for kicks or for the hell of it and the man who has a genuine drinking problem. The former may benefit from a good dose of judgment. The latter cannot be lectured or preached out of his problem and is probably overburdened with guilt already.

Many of the clergymen I know have reached this stage, at least, in their understanding of alcoholism: they know that problem drinkers are in need of help more than judgment; they are ready to be open and accepting in their relationships with them. But the world has not received this message yet. The association of the old narrowly judgmental attitude with the clergy and the Church still remains. Our communication with the world is inadequate. Theologically we say that our churches are congregations of sinners, accepted by God as righteous only through His grace. But the fact is that the world thinks of us as congregations of the self-righteous—and not without justification. A couple once came to me for help because their marriage was breaking up. They were active members of a church in a neighbouring

community, and I asked them why they had not gone to their own minister. They said they did not want to sit in church services knowing that their minister knew they were in this kind of trouble. If they as church members saw the Church as a fellowship of the strong and the righteous, then what must the outsider think?

Passing the buck

Some clergy who have dropped the judgmental attitude have adopted a dangerously superficial understanding of alcoholism. They define it as a disease that can only be treated by a medical doctor or by a psychiatrist, or perhaps by Alcoholics Anonymous. Despite their claim to believe in the interrelatedness—the wholeness—of man's body, mind and spirit, they are all too ready to transfer problem drinkers to another profession or agency.

Often there are practical reasons for this abdication. Like people in other healing professions, the clergy know that a relationship with an over-drinker can be a messy, exhausting, long-term business. There may be many good reasons to refer people to other agencies. But again, what is the actual image of the clergy seen by the person with the problem? I think of the woman with a drinking problem who finally got up courage to speak to her clergyman, and five minutes after the conversation began she left the church with a packet of offering envelopes in her hand. I think also of the young man who bitterly accused the clergy of being institution-oriented—concerned, not about the individual's welfare, but about how the individual may be useful to the institution of the Church.

I am convinced that the Church has a vital and essential role in the treatment of over-drinkers. Listen to the questions they raise and you will agree that these should be the concerns of the Church. Here are some of the topics one group of patients wanted to discuss: loneliness and the inability to communicate; guilt and "the scars on my mind;" ethical values; purpose in life and the feeling that we matter; fear of disappointment; prayer—can it help?; living without the crutch of alcohol; ultimate and

intermediate goals in living; drinking as the desire for self-destruction; and "What do you do when you try to live by rules and the damned rules don't work?" Surely the Church has something to say about these questions; and surely, enough inspiration is given us to help people find answers in their own language.

The Church's attitude to "the normal use of alcohol" is a very controversial subject — an area where we need an ecumenical encounter among the churches. Personally, I think the Church must come to a clear definition of its position regarding the freedom of a man to drink or not to drink. I agree that there are too many compulsions in our society against the freedom not to drink—too many prejudices against the non-drinker—and the Church rightly protests against these. But, for its own part, is the Church ready to accept openly as legitimate the decision of the person who honestly and temperately accepts his freedom to drink? The negative attitude of many churchmen to the act of drinking itself blocks off many people from communication with the Church. I believe it would be easier for a problem drinker to approach a clergyman with his total life-need if he knew that the fact of drinking in itself was not a barrier to their relationship.

The Church should listen

In summarizing this analysis of current attitudes in the Church, I reiterate my conviction that the Church is commissioned to help offer healing to the over-drinker. Its motive in so doing is not the negative fact that the over-drinker is a threat to society; the Church is not just a guardian of social safety and morality; we should be of little help to the over-drinker if this were the basis of our approach. The Church is a community of believers seeking to share the life—the real life they have found through faith—with people who have lost that life or never found it. In approaching people with this motive, the Church should begin by accepting them as people, opening its mind and heart to listen to what they are actually saying and to understand the needs they themselves feel.

I have already pointed out that many of the questions raised by the over-drinkers are the life issues that are the concern of the Church. The Church's teaching should presumably be of help in finding answers; and it will be, if the Church can get out from under much of its theological religious jargon and speak the language of the people. In this part of the address, I intend to take a quick look at six facets of the Church's teaching that need to be thought through in their relationship to the problem of alcoholism and translated into secular language. I am not attempting to discuss them thoroughly, nor is this an exhaustive list. It is the result of my own recent experience with problem drinkers, and represents areas of discussion that, to some extent, they have found meaningful.

At the crossroads

1. I return briefly to the Church's teaching about judgment precisely because we have tended in the Church to limit it to negative moral condemnation based upon values that are much more relative than we are willing to admit. The biblical meaning for judgment is much more creative and positive, suggesting an opportunity to enter a new and good way of life. The Greek word is *krisis*, and it gives us a picture of a man at the crossroads, his very life in danger if he continues on his old way, but also a great hope before him if he chooses a new way. I believe it can be of real value to an over-drinker to help him interpret his own self-judgment in terms of a crisis that can offer a positive possibility as well as a negative threat.

2. One doctrine of the Church that I have heard discussed frequently under various guises in the clinic is the concept of justification. In one discussion, which the patients initiated themselves, I listed five separate statements that indicated they were wrestling with a frantic longing for self-justification. They appeared desperately determined to prove by themselves what great people they could be. One said abjectly, "I am terribly guilty," and was quite ready to accept the judgment of another that his guilt was just the other side of his pride. Three statements had

to do with the need to be loved: "I shall remake myself into a lovable person, within reasonable limits;" "I *am* a lovable person;" "I am trying to win friends." The fifth statement was a familiar cry in an alcoholism clinic: "I want control of myself."

To me, these statements signify people struggling to prove their personal worth and not succeeding too well at the job. They are deeply frustrated in trying to achieve the profound acceptance they long for. There is frequent discussion of the need for acceptance, and I believe "acceptance" may be the word we should use to get at the Church's teaching about justification. Certainly the symptoms of frustration in modern man trying to achieve acceptance show an interesting similarity to the symptoms of frustration in the people of the Bible trying to reach self-justification: a growing sense of isolation even as they long for a meaningful relationship with another being; extreme vulnerability and sensitivity to criticism; and a lack of peace. Here are people haunted by their image of themselves as skilled con artists, who recognize their own talent in manipulating other people's impressions of them, and who despise their own dishonesty.

It is very difficult for a therapist to convince the patients that he accepts them simply because they are human beings. They tend to conclude that they have manipulated him, too, into this acceptance.

There is one person, of course, whom none of us can manipulate, and that is God. Here the Church has something to offer in helping the over-drinker to learn the liberating effect of accepting in faith God's acceptance of him.

Drugs as a comfort

3. One word frequently used by medical doctors and nurses has greatly interested me: that is the word "comfort." When they speak of "making a patient comfortable" they are often referring to the use of drugs by which the patient's existence can be made tolerable. Churchmen can recognize the importance of drugs as a form of comfort: a negative, passive, artificial form, but necessary in order to live through what might otherwise be an unbearable

able experience. Perhaps we should give more thought to alcohol's having a legitimate place as such a negative but necessary comfort at certain times. I often wonder how some of our patients would survive at all if they did not have it, in the absence of a better solution.

Expressing anguish

I believe there is a better, positive, more creative form of comfort, and a study of the biblical teaching about it would be helpful in regard to the over-drinker. When the biblical writers spoke of "finding comfort" they meant a situation in which they had freedom to express their anguish or sorrow in the presence of someone who they knew cared about them—particularly God. One biblical word for finding comfort literally means "giving forth sighs," "groaning." The Book of Lamentations suggests that one of the worst things that can happen is to have no one who can comfort you in this sense.*

We can see an important role for the Church here if we are true to the commission that we should "bear one another's burdens." Taylor Caldwell, in her book *The Listener*, has taught the importance for our age of having someone to whom our anguish of soul may be expressed. The presence of the listener is essential, for without it the expression of the feeling does not produce adequate results. And it is important also that the listener should somehow be able to communicate a sense of hope. There is a Scottish story that illustrates this point:

Sandy and Jock had been overindulging at the local pub. At closing time they began weaving their way home through a violent thunderstorm. They had just reached a particularly narrow part of the path when a brilliant flash of lightning threw them completely off balance. Jock was pitched head-first into a deep ditch. Sandy saved himself only by grabbing and clinging to a fencepost. In a moment, out of the darkness of the ditch came Jock's woebegone voice: "Sandy, will ye no' come and

* Lam. 1: 2, 9, 16, 17, 21.

help me?" Sandy gathered his thoughts and replied, "Jock, if I let go this post all I could do would be lie down beside you."

Identification in itself may be some solace, but it is much better if it carries with it a hope of endurance or improvement.

In the Greek New Testament, the word *paraclete*, sometimes translated as "comforter," means a person called to be beside another to speak on his behalf and enlist sympathy for him. It refers in particular to the Holy Spirit of God and generally is connected with the belief in the power of God to help a person up out of trouble.

Somehow the Church must become for the over-drinker a comforting community according to the biblical definition—not piously and sentimentally comforting, but positively and strongly. We can make a beginning by learning to listen and letting ourselves be used by people to express what they need to express.

Sin as rebellion

4. One of the most troublesome words in the Church's vocabulary is "sin." How many promising conversations have been cut off by the introduction of that word! We are dogged by misconceptions of its meaning. I confess that I have not been too successful in getting across to others what I believe is the biblical meaning. Some have suggested that we substitute the word "sickness" for "sin." This is justified by Jesus' reference to himself as a physician who came to heal the sick. I cannot accept the substitution as adequate because it does not do justice to the idea of rebellion, which is part of the biblical teaching and which is intrinsic to the Bible's very high concept of man. At the moment, all I can say is that we need to struggle with the interpretation of this word.

5. John Steinbeck has a humorous account of his experience of listening to a preacher of the old school denouncing the sins of the congregation. He says that he left the church with a renewed sense of his own importance. Says Steinbeck, "I hadn't been thinking very well of myself for some years, but if my sins had this dimension there was some pride left." Anyone whose sin was

as serious as this must be of considerable value in the divine scheme of things. Steinbeck's humour here may be quite valid theologically. At any rate it leads me to another Church teaching that is of great importance for the over-drinker: the belief in the continuing worth of the human, even at his lowest. The Church has a great gift to offer despairing people in revealing to them their great destiny as children of God made in the image of God. Upon this fundamental faith in man's destiny can be built the hope of change, responsible living and freedom, which the over-drinker needs to believe in.

Emphasize joy

6. Finally, another aspect of the Church's faith needs emphasis, and that is joy. The heresy of negative Christianity of the "thou shalt not" school has robbed the Church of much of its joy, so that outsiders sincerely wonder what advantage there is to being a Church member. Christians are sometimes rightly accused of a kind of masochism that finds a perverse pleasure in wallowing in guilt. Many of us Presbyterians are subject to this. We have a favourite hymn that includes the lines:

"Sing to the Lord with cheerful voice,
Him serve with mirth,"

and inevitably we sing it like a funeral dirge. We have a need to understand what our forefathers meant when they said, "Man's chief end is to glorify God and enjoy him forever."

I remember hearing one over-drinker say that he was afraid of experiencing even the simplest joys because they inevitably intensified the contrast with the anguish of most of his life. If the Church really believes it has "good news of a great joy" then it should be able to help such a man in daring to enjoy.

I have spent much time on theological issues, and perhaps some of you are saying, "Enough of such high-flown talk, let's get down to practical issues." Well, I have taken so much time deliberately, out of the conviction that these theological issues are intensely practical. If the Church is to have a helpful role

in therapy then it must think through its "good news" in relation to the over-drinkers' needs.

In considering how the Church should fulfil its role in therapy we need to ask first, who are the therapists? Here we begin with recognition of the responsible therapists and agencies outside of the church institution. Clergymen need to learn from consultation with them and develop procedures for referral of patients.

Within the institution, careful analysis of the variety of gifts represented among the clergy and laity is required. It is not everyone who has the necessary gifts for a therapeutic pastoral relationship with over-drinkers or the attitudes conducive to such a relationship. I am convinced that the Church should develop a specialized ministry for this work. We need to seek out the right people, train them carefully and give them freedom and facilities to do their job.

I think it would be a valuable experiment for us to try to organize some therapy groups of over-drinkers within the structures of our churches. Over-drinkers have demonstrated in Alcoholics Anonymous that they can provide a healing ministry for each other. I believe this procedure could be considerably abetted if it were linked in with the Church's teaching ministry. We need to exploit intelligently the fact that the Church is present in many communities where no other therapeutic organization exists.

At the parish level

This observation leads us to another question: What can be done within the local congregations or parishes?

One important function is a carefully planned program of education on the use and abuse of alcohol. Researchers are unanimous in pointing out the need for building up a social climate of understanding of alcoholism. The Church can usefully co-operate in this matter with government and private agencies. In my own congregation a special group of people has been organized to carry out such a project.

Then there is the matter of relating the recovering over-

drinker back into society. The problem here is similar to that faced by those who have experienced mental illness and are re-entering the community. Well-prepared congregations can serve a most useful role in helping recovering over-drinkers make the difficult transition back into the normal life of the community.

Open the doors

Finally there is the troublesome problem of seeking out the over-drinker with a view to getting him help before his trouble has advanced too far to be helped. This is admittedly a touchy problem. To suggest treatment may lead a person to feel antagonism towards it. I know many clergy are often faced with this dilemma when they hear by the grapevine that someone among their people is over-drinking. It is worth considering that we clergy are just about the only people in our society who are granted free access to many of the homes in our communities. If we use this freedom to visit the home of a rumoured over-drinker, we should not attack the problem head-on. The important thing is to open up doors of communication, let people approach the problem as obliquely as they wish, and build up the trust that will enable them to get to the core of their need. If it achieves nothing else, at least it may provide a supportive role for the family. I do think we have been too much overawed by the assertion that nothing can be done for the over-drinker until he reaches the bottom and is driven to admit his problem.

In conclusion, I reaffirm my conviction that the Church has a vitally important contribution to offer in dealing with the problem of alcoholism. But we shall have to overcome a great deal of lethargy and prejudice within ourselves and our people if the contribution is to be made. Of one thing I am certain: the Church that follows Him who did not hesitate to sit down with the outcasts of society must not ignore its responsibility to the over-drinkers. Otherwise His judgment will be directed upon us: "Inasmuch as you did not minister to one of the least of these, you did it not to me."

A.I.T. Addictions



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Addictions

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Winter, 1966

Responsibility and Addiction: A Psychiatric Approach

by John D. Armstrong, M.D., D.Psych.

A common concept in law is that the ordinary reasonable man intends—can predict, understand and accept—the natural consequences of his acts; thus he is held to be accountable, or answerable, or responsible for those consequences. In practice, however, one often cannot give a simple yes-or-no answer to the question whether a particular person is responsible for the consequences of a particular act that he has committed. Psychiatrists especially are often called upon to deal with cases in which the decision is not all that easy.

The concept of “intending the natural consequences of one’s acts” is largely ineffective unless our system of evaluation is based solely on observed behaviour and no importance is attached to the motive behind the act. In such a system, the act is more important than its causes. The Mosaic Law was “life for life, eye for eye, tooth for tooth.” This concept has changed

Dr. Armstrong is Director of the Mental Health Clinic at the North York General Hospital, maintains a private practice in Toronto, and is a lecturer in the Department of Psychiatry at the University of Toronto. He was Medical Director of this Foundation from 1953 to 1964. He delivered this paper to the course in forensic psychiatry at Queen’s University in August, 1963. It was later printed in the *Canadian Psychiatric Association Journal*, 11, 2 (March-April, 1966) 116-122, under the title “Responsibility and Addiction.” It is reprinted here, slightly revised, with Dr. Armstrong’s permission.

a great deal through the years, and we now understand that many factors may influence a person's responsibility for his actions.

Addiction to chemicals

One major area in which the problem of responsibility is encountered is that which deals with addiction to various chemicals. The commonest and most damaging of these is alcohol, but there are many others. The most notorious seem to be the so-called narcotic drugs, but many dangerous addiction problems arise from the use of barbiturates, tranquillizers, bromides — which, by the way, can be bought in a grocery store — amphetamines and other substances. I will not deal with the specific effects of these drugs, but each of them produces its own characteristic forms of intoxication and of serious disturbance.

Many laws regulate the manufacture, sale and use of alcohol and other drugs, and infractions of these laws may bring persons into the courts; but from the point of view of our interest here, the greatest legal problems associated with alcohol and other drugs occur when the use of these chemicals induces behaviour that is not acceptable to the community.

There is a considerable variation in the seriousness with which problems involving various chemicals are regarded from a legal point of view; and the degree of seriousness seems to have little to do with the actual dimensions of the problem as seen from a psychiatric or medical point of view. For instance, a man convicted of simple illegal possession of heroin or marijuana can be sentenced to anything up to seven years' imprisonment, whereas a man can consume another drug — ethyl alcohol — in extraordinary quantities, get behind the wheel of an automobile and drive in a manner highly dangerous to the community, and draw a much lesser sentence.

It seems that we are much more content to lock the narcotic addict up, and in fact many people are disturbed at trying to handle him in any other way; but when attempts have been

made to change the laws to permit the committal of certain very dangerous types of alcoholic, there has been a great outcry — this despite the fact that alcoholics in Canada number well over 237,000, whereas it is believed that the total number of narcotic addicts is something like 3,500.

In this paper, however, our concern is not with these legal inconsistencies, or with the special characteristics of certain drugs, but to try and see how the processes of addiction influence our ability to view a man as a rational being who can assess and accept the consequences of his behaviour.

Concept of impairment

Now any one of us is subjected constantly to influences that alter — impair or, rarely, enhance — our ability to exert good judgment and to determine fully the consequences of our behaviour. The makers of our traffic laws in Ontario lay great weight on the concept of impairment; here they are thinking especially of ethyl alcohol, but it has become more obvious recently that impairment due to other drugs is equally serious. However, many other factors impair our judgment and our capacity to evaluate and effectively implement our plans of action. On the physiological side, fatigue, hunger or any state of acute or chronic illness tends to lessen our ability to make appropriate decisions and plans and to carry them out.

Equally important, and perhaps more frequent, and certainly more capricious, are the effects of our emotions: when we are angry, depressed, anxious, excited or elated, we tend to function less well than at other times; often our responses are out of proportion to the stimuli, and repetition makes certain responses more easy. There are even rare moments when we feel that everything is so well under control that we cannot make a mistake; this can be a delusion indeed.

Quite apart from any transient or variable interferences such as those mentioned above, there are some basic characteristics of mental competence and emotional stability or temperament that are fairly fixed within the individual and that in themselves

influence the degree of response to certain situations. When an impairing drug comes into the picture and is combined with certain states of chronic emotional disturbance in a particular individual, there seems to be a disproportionate degree of disturbance. Actual intelligence does not seem to be a major factor in mental competence, although one can imagine that a person of lower intelligence presents different kinds of problems, when habituated to any drug, than a person of higher intelligence.

Capacity to form intent

The essential problem to be faced in the presence of a drug user is his capacity to form an intent: his ability to decide upon, plan and develop a course of action. Now when we are considering capacity to form an intent, we must recognize a number of areas in which interference might occur. These include perception, assessment, judgment, decision, implementation, emotional lability and muscular co-ordination.

One of the things that a person under the influence of alcohol may do is misinterpret events that are taking place about him; he may even be unable to comprehend more than the crudest aspects of the situation in which he is involved; as a result of this misinterpretation, he may decide on a plan of action—getting into a fight, getting into some kind of sexual involvement—that he would not decide on if he interpreted the situation correctly. He would also be likely to misinterpret traffic situations grossly.

Again, a person's perceptions may not be grossly impaired, but his ability to use discriminatory judgment may be. Thus he might be less inhibited about indulging in behaviour that would be unacceptable to him if he were sober: using inappropriate language, carrying out a sexual act or a criminal act, making a long journey and the like. Of course, his competence in managing an automobile, and his reactions to minor annoyances in traffic, might be greatly distorted.

Also we may find enough interference with emotional con-

trol that a degree of lability — rapidly shifting emotions — may exist and bring about a degree of elation, excitement, annoyance, anger or depression out of all proportion to the situation, interfering with the capacity to make a normal judgment and resulting in a mistaken and exaggerated course of action.

Finally, there may be gross mechanical malfunction — gross interference with the physical capacity to carry out a plan. Sometimes this results in gross inability to meet an emergency effectively; it may cause a person to misjudge his actions and strike a fatal blow which he did not intend to be fatal. A person in this condition may be able to get into his car and start it, but he cannot steer it accurately enough or brake quickly enough to avoid what would normally be a close shave or, at the most, a minor accident, with the result that there is gross damage, injury, and perhaps even death. Sometimes a person is so incapacitated that he cannot strike a blow, or commit a sexual act, or manoeuvre a car in any serious way.

Degree of impairment varies

One should recognize here, however, that even the degree of impairment is not absolute or constant. For instance, we may have a person who is very much under the influence of alcohol and yet in the eyes of the law is still quite controlled in carrying out certain actions. A man who has been drinking all night and is beginning to have the shakes in the morning goes to a wine store at opening time—10 A.M.—and buys a bottle of wine. He knows that this bottle will give him relief from his shakes as soon as he drinks it, but he can still exert enough control to carry it to a safe place—out of sight of the police—before he opens it.

The question of responsibility becomes very important in serious criminal cases such as homicide, which may be classified as capital murder, non-capital murder or manslaughter, depending on the degree of the accused's responsibility. A man under the influence of alcohol may be so disturbed in any of the areas mentioned above, particularly in emotional lability, that while he perceives correctly what has been going on and

forms some intent to strike a fatal blow, he would not have done so if he had not been impaired, and hence he does not fit the criterion for capital murder: the ability to plan and deliberate his act. On the other hand, it is also possible — but more difficult to define precisely — for a person to have a state of disturbance in which there is so much impairment of all the aspects of mental ability — perception, assessment, judgment, planning and execution — that one can say that in fact he does not know what is happening because of his state of drunkenness: that he has so thoroughly misjudged the situation, both as it affects him and as he acts, that he can be said to have no intent to kill, and so cannot be considered guilty even of non-capital murder.

Components of addiction

We should consider the components of addiction briefly in order to get some concept of the process by which a person has less and less control over his own behaviour and hence more and more interference with his responsibility. Here it may not matter what addicting substance we are dealing with, whether it be alcohol, barbiturates or heroin, or perhaps even such things as tobacco, coffee or food. Primarily the drug used must present a welcome, useful effect to the user. This effect may be related to a physical, psychological or social situation. The drug may relieve pain or ease tension, or it may simply reflect a custom of the group to which the person belongs and be a means of facilitating the group's acceptance of him.

Once an action has been found useful, there is likelihood of repetition. The more meaningful the beneficial effect of the drug is to the user and the more acceptable it is to the group, and the more available it is, the greater the rate of repetition will be. If the repetition is frequent enough, dependence develops; the drug has now become the user's prime source of relief, and his desire for it has become so great that we call it a compulsion.

Now a new effect takes place: increased tolerance. Orig-

inally a certain dose is required to produce a given desired effect; but after a while, when the drug has been used repeatedly, a much larger dose is required to produce the same effect. With some drugs there can be many successive increases in the dose that is required, so that after a while the user is taking many times the original dose in order to get the original desired effect.

Withdrawal symptoms

By contrast, if we suddenly take the drug away, specific symptoms occur which we call withdrawal symptoms. These are definite physical responses to the unaccustomed absence of the drug from the organism. These last two characteristics — increased tolerance, and withdrawal symptoms — are necessary to fulfil the strict definition of addiction as distinct from mere habituation.

The important point about addiction for the purpose of this paper is that as the user becomes increasingly dependent on the drug, there is a gradual deterioration in the nature of his behavioural responses and an increasing predictability of certain unplanned and undesired responses: the alcoholic gets drunk, the narcotic user goes on the nod, and so on. Paralleling this experience with the drug is the fact that the person is less able to make appropriate decisions than he would have been when completely sober. His behaviour and its consequences seem somehow tied in to his drug use more and more, rather than seeming to be a true part of his determined behaviour; and while, if challenged, he might say "What I do is my own business," it is equally likely that he never would have predicted and determined that he was going to be an alcoholic or an addict or whatever it is that he has become. There has been a change in the person, so that he is more capable now of getting into situations where he is likely to get into a fight, or likely to drive a car in such a way that he might kill someone, than he would be otherwise.

We must remember that with each individual, the combination of his psychological makeup and the drug he uses may

cause an entirely unique set of circumstances, so that the alteration of one drug user's responsibility may be quite different from that of another's. For instance, the problem of a seventeen-year-old Harlem youth whose normal social group involves him in narcotic use, vandalism and sexual promiscuity is quite different from that of a fifty-year-old Toronto matron, now menopausal, whose children have grown up and who essays three or four martinis before dinner to meet a host of little fears, or that of an advertising executive who spends his business day in an almost continuous state of self-induced alcoholic confusion as a concomitant of his job.

Degree of responsibility

Yet, somehow, we have to measure the degree of intent and responsibility in each instance. When the Harlem youth knifes and kills a member of a rival gang, when the housewife sets fire to her mattress and is rescued in the nick of time, when the executive rams another car, causing considerable damage, is the youth guilty of capital murder? Is the housewife so incapable of management that she requires committal to a hospital? Should the executive be deprived of his driver's licence, either as a punishment, or as some form of deterrent, or because he cannot exert responsible judgment and is a danger to other drivers? There are degrees of responsibility, but there are also degrees of predictability and probability that will influence the kind of control we may recommend in each given situation, if, in fact, we recommend anything. Far too often, in the case of the fifty-year-old woman, for example, there is a history of a series of burned mattresses until finally tragedy strikes, and no question of responsibility is ever raised.

In the case of the alcohol addict, our problem is often compounded or added to because there may have been actual brain cell damage; but in many instances, because of the crudeness of our measuring techniques, our estimate of this kind of damage is highly speculative. Thus we can only express an opinion as to the degree of responsibility and the degree of permanence

of any interference with responsibility. This becomes particularly important if our decision involves some expectation that a person's health be subject to treatment and control.

It should be recognized, too, that in many instances addiction is only one of the factors affecting the degree of an addict's responsibility. There may often be a serious disorder underlying his addiction: perhaps depression, in which he does not care about the consequences of his behaviour, or a schizophrenic disorder in which his judgment is grossly disturbed — possibly as a result of delusions — or various character disorders in which there are specific patterns of compulsive deviant behavior, or one or more of many other psychiatric problems.

This problem of responsibility is especially important when the matter of sentencing comes up. Clearly, if we accept that the alcoholic or the addict is a disturbed or sick person, then the disposal of the case must take this into account. Before we can make a decision on disposal, we must know what the problem is, and we must know something not only about protecting the community by restricting the offender, but also about aiming towards his rehabilitation. The drinking driver's problem is little solved when he pays a fine if no one takes the trouble to find out what his problem is or to find out if anything is being done about his problem. He may feel, in fact, that he has paid for his error and that he is free to drive again without mending his ways—almost as if he had been given a new kind of licence.

Killed wife he loved

The same thinking can be applied in many areas. For example, I recall a case in which a man killed his wife in a drunken brawl. He loved his wife, he had not fought with her previously to any great extent, and, in fact, he seldom fought at all; but when we looked into his record we found that this man — a hard-working, steady man, living with his family — had shown increasing use of alcohol over the previous few years. There had been quarrels, there had been police involvements, there had even been fines, all in a period of two or three years

prior to the final event. In each case this man was judged wholly responsible, given a definite punishment, and turned loose. Eventually he committed a homicide which he neither intended nor desired, and he was required to serve a long sentence which may have had little relation to his basic problem.

Examine our attitudes

How much would it have helped, at that late date, to try to understand how this man saw the nature of his offence? Does a definite number of years of restriction help bring home to this man that he has done wrong? Could we have tackled this in some other way? Should we not take more responsibility, as a community, for examining how various drugs change people's abilities? Do our attitudes to the drugs themselves require examination? There is a great contrast between the way in which we look at alcohol — seemingly a relatively safe drug — and the way in which we look at narcotics — seemingly very dangerous drugs. The relatively safe drug, alcohol, causes much more damage and many more deaths in our community than do the narcotics.

In summary, then, drugs influence the degree of a person's responsibility for his acts in two ways: in the degree of impairment due to intoxication, and in the degree of dependence, whether psychological or physical, or both. In dealing with a drug user who is accused of an offence, we must examine his drug problem carefully in order to determine the extent to which his responsibility is diminished by the drug, whether the drug in question be a narcotic, a barbiturate, a tranquilizer, an amphetamine, a bromide, or ethyl alcohol; and we must try to determine an effective way of enabling him to function free of the restrictions that have been imposed on him by the drug that has diminished his responsibility.

Responsibility and Addiction: The Law in Canada

by E. R. Alexander, B.Comm., LL.B., LL.M.

The problem of the criminal responsibility of alcoholics and drug addicts is a small part of the addiction problem. The ultimate solution to the total problem—the eradication of addiction—requires a multi-disciplinary approach in which law will play a relatively small part. The leading roles will be played by medicine, psychiatry, psychology, pharmacology, sociology, and anthropology. This is not to deny that law and lawyers will contribute to any ultimate solution. To be effective, however, the legal contribution must be integrated with other more important contributions.

Addiction and Crime

In discussing the possible relationship between addiction and crime, one must distinguish between crimes closely related to addiction (crimes arising out of the use of alcohol and the use or possession of drugs) and other crimes. For example, in connection with addiction-related crimes, it seems that a large percentage of the convictions for public drunkenness,¹ and intoxicated² and impaired³ driving, involve alcoholics. Similarly, since the inevitable result of the continual use of narcotics is addiction, it seems that most, if not all, convictions for illegal possession of narcotics⁴ involve drug addicts.

The relationship between addiction and other crimes is not so obvious. In this respect there is a difference between alcohol

Professor Alexander is an Associate Professor in the Faculty of Law at the University of Toronto. He previously occupied a similar position at the University of Ottawa. He delivered this paper as part of a symposium on comparative law at the University of Ottawa in September, 1965. We have abridged the paper for the purposes of this magazine, omitting background material on addiction problems, which would be familiar to most persons working in this field, and also omitting many footnotes that would be of interest mainly to lawyers. The complete version of Professor Alexander's paper appeared in the June, 1966, issue of the *Saskatchewan Bar Review* (Vol. 31, p. 71), under the title: "The Criminal Responsibility of Alcoholics and Drug Addicts in Canada." We suggest that lawyers especially might be interested in reading the complete version.

addiction and drug addiction — at least narcotic addiction. Since only a small proportion of those who drink become alcoholics, the important relationship for investigation would not seem to be that between alcoholism and other crimes, but rather that between *the use of* alcohol and other crimes. If this relationship can be established, alcoholics will doubtless be involved in a high percentage of alcohol-related crimes. For narcotic drugs, since the inevitable result of continual use is addiction, this distinction between addiction and mere use would appear to be unimportant.

There is a relationship between narcotic drug addiction and other crimes. However, the view of the narcotic addict — at least the opiate addict — as a violent criminal is untenable. The narcotic addict is most often convicted of theft, sale of narcotics to others, and, if a woman, prostitution. "It is not narcotic drugs themselves, but rather their exorbitant black-market cost that forces most addicts into criminal pursuits. It is significant . . . that those addicts who can afford the high prices usually do not engage in crime and are, thus, unknown to the courts."⁵

As far as I have been able to discover, no investigations have been made into the possible relationship between addiction to or use of non-narcotic drugs and crime.

Criminal Responsibility

Under the British North America Act, the federal parliament has legislative jurisdiction over criminal law except for its administration and the constitution of criminal courts, which are committed to the provincial legislatures.

Canada expressly professes that her criminal law is based on that of England. . . .

The primary influence not only on Canadian penal jurisprudence but also on Canadian penal legislation has . . . been English law, and not only the common law but also the great body of English 19th-century legislation that embodied sweeping reforms in the rules of criminal law defining offences, determining responsibility, and prescribing punishments, in the

system of criminal courts, and in criminal procedure. One reform that the English refused to make was adopted in Canada, namely the codification of criminal law and procedure. . . . Since creating her own Code, Canada has been less inclined to follow the English lead, but has become more independent in the development of substantive law and even more so in the creation of her own system of courts and criminal procedure. . . .

The main body of national criminal legislation is, of course, contained in the Criminal Code, the latest revision of which came into effect on April 1, 1955. On this revision, the last remaining common-law criminal offences have been abolished in Canada, but common-law principles relating to liability, justification, and excuse continue in effect, except insofar as replaced or modified by Canadian legislation.⁶

Criminal responsibility requires certain mental elements: most crimes require an act and a guilty mind (*mens rea*) accompanying the act. This concept is embodied in a traditional English legal maxim: *Actus non facit reum, nisi mens sit rea*: An act does not make [the doer of it] guilty, unless his mind be guilty.⁷

The act and the mind

An accused who did not act will escape criminal liability.⁸ An act is a voluntary muscular contraction: a muscular contraction that is willed, one in which the mind accompanies the contraction. In terms of this definition, an involuntary muscular contraction is one that is not willed — a contraction of the muscles without any control of the mind — for example, a muscular contraction of a person in a state of unconsciousness, as in sleep. The criminal law defence of no act is known as the defence of automatism.

Besides an act, criminal responsibility generally requires that the accused had a guilty mind: the mind must not only accompany the muscular contraction, it must generally be guilty.

The *mens rea* required for common law crimes varies widely. Some require a specific intention, some require either specific intention or recklessness as to the consequences of an act, and for the felony of manslaughter negligence will suffice if it is of a sufficiently high degree. In one common law crime, the misdemeanor of public nuisance, no *mens rea* at all is

necessary, in that a master may be vicariously liable for the act or default of his servant. . . .

A statutory crime may or may not contain an express definition of the necessary state of mind. A statute may require a specific intention, malice, knowledge, wilfulness, or recklessness. On the other hand, it may be silent as to any requirement of *mens rea*, and in such a case in order to determine whether or not *mens rea* is an essential element of the offence, it is necessary to look at the objects and terms of the statute.⁹

Addiction *per se* is not a crime; nor is it a crime to be under the influence of alcohol¹⁰ or drugs. The main crimes related to addiction are causing a disturbance by being drunk in a public place,¹¹ driving while intoxicated,² driving while ability to drive is impaired,³ and unlawful possession of narcotics.¹² In 1962 in Canada, the last year for which complete statistics are available, there were, under the Criminal Code, 3,765 convictions for causing a disturbance by being drunk in a public place, 1,542 convictions for driving while intoxicated, and 25,057 convictions for driving while ability to drive is impaired, and, under the Narcotic Control Act, 264 convictions for illegal possession of narcotics.¹³

Addiction no defence

Addiction *per se* is not a defence to these addiction-related crimes: in determining criminal responsibility no allowance is made for the accused's addiction. What about the effects of alcohol or drugs in connection with the criminal responsibility requirements of action and *mens rea*? Can a person be under the influence of alcohol or drugs to such an extent as to be incapable of action, or, although capable of action, can his condition be such as to negate a guilty mind? For example, a person might be physically in charge of a car but might not know what he is doing, or might not know that what he is doing is wrong, and thus it might be supposed that he could not be convicted of intoxicated or impaired driving. In such cases, however, our courts have found — perhaps fictitiously — the necessary action and guilty mind from the circumstance that

the accused drank the alcohol or took the drug voluntarily. "Voluntarily" in this context means only that the accused knew he was consuming alcohol or taking a drug, and knew the effect an excessive dose would have on him.

McCormick appeal fails

Regina v. McCormick,¹⁴ a case involving a charge of intoxicated driving under section 222 of the Criminal Code,¹⁵ illustrates this approach. The accused, who had been and was drinking heavily, and a companion were out in the accused's car, the companion doing the driving. The accused had no intention of driving at the time he got into the car. An argument developed and the companion left the accused alone in the car with the engine running. Between the time he entered the car and the time his companion left him, the accused's "drunkenness had progressed to the point that he was completely incapable of conscious reason. He did not know where he was or what he was doing and in fact was suffering from complete amnesia due to the consumption of alcohol."¹⁶ While in this state the accused attempted to operate the car and succeeded in moving it a few feet. At the time he was arrested the accused was occupying the driver's seat and the engine was running. The accused admitted he was intoxicated within the meaning of section 222.

In affirming the conviction for intoxicated driving, the Saskatchewan Court of Appeal, relying on the case next to be discussed,¹⁷ held that while *mens rea* is an essential element of the offence it is established by proof that the accused voluntarily consumed alcohol. Presumably — it was not argued in the case, but the accused's condition leads to this presumption — voluntary consumption of alcohol satisfied the criminal responsibility requirement of an act as well. The result of the *McCormick* case may be justifiable on a policy basis, but the findings of action and *mens rea* seem, on the particular facts, highly artificial.

On the other hand, if the accused did not become intoxicated or impaired voluntarily, either because he did not know he was

consuming alcohol or taking a drug, or because he did not know the effect it would have on him, this may be a defence.

King appeal succeeds

In *The Queen v. King*, a case involving a charge of impaired driving under section 223 of the Criminal Code,¹⁸ the facts were these: Before the accused had two teeth extracted by his dentist, he was injected with sodium pentothal, a quick-acting anaesthetic, which produces unconsciousness. After regaining consciousness the accused was warned not to drive until his head was perfectly clear. The accused said he did not remember the warning, but that he did remember getting into his car and driving a short distance, after which he became unconscious. The accused said he did not know anything about the effects of sodium pentothal.

Medical evidence was given to the effect that this mental . . . condition was consistent with the after-effects of being injected with sodium pentothal and that this drug may induce a state of amnesia accompanied by a period during which the subject may feel perfectly competent to get in a car and drive and in the next second or so be in a condition in which he would not know what was happening.¹⁹

There was no doubt that the accused was in fact impaired within the meaning of section 223.

The Supreme Court of Canada affirmed the Ontario Court of Appeal's²⁰ reversal of the conviction. The question referred to the Court was "whether the Court of Appeal erred in law in holding that *mens rea* relating to both the act of driving and to the state of being impaired by alcohol or drug is an essential element of the offence of driving while impaired, contrary to section 223 of the Criminal Code." In the course of his judgment²¹ Ritchie J. said: "The respondent's sole defence was that he had no knowledge of the effect of the drug which resulted in his being unaware of any warning and unaware of the fact that he was impaired when he took the responsibility to drive and did drive his car."²²

In answering the question referred to the Court, Ritchie J. said:

I do not think that the Court of Appeal erred in holding that *mens rea* was an essential element of the offence of driving while impaired contrary to s. 223 of the *Criminal Code*, but I am of opinion that that element need not necessarily be present in relation both to the act of driving and to the state of being impaired in order to make the offence complete. That is to say, that a man who becomes impaired as the result of taking a drug on medical advice without knowing its effect cannot escape liability if he became aware of his impaired condition before he started to drive his car just as a man who did not appreciate his impaired condition when he started to drive cannot escape liability on the ground that his lack of appreciation was brought about by voluntary consumption of liquor or drug.²³

Presumably voluntary consumption of alcohol also satisfied the criminal responsibility requirement of an act.²⁴ Ritchie J. had earlier said:

The existence of *mens rea* as an essential ingredient of an offence and the method of proving the existence of that ingredient are two different things, and I am of opinion that when it has been proved that a driver was driving a motor vehicle while his ability to do so was impaired by alcohol or a drug, then a rebuttable presumption arises that his condition was voluntarily induced and that he is guilty of the offence created by s. 223 and must be convicted unless other evidence is adduced which raises a reasonable doubt as to whether he was, through no fault of his own, disabled when he undertook to drive and drove, from being able to appreciate and know that he was or might become impaired.

If the driver's lack of appreciation when he undertook to drive was induced by voluntary consumption of alcohol or of a drug which he knew or had any reasonable ground for believing might cause him to be impaired, then he cannot, of course, avoid the consequences of the impairment which results by saying that he did not intend to get into such a condition, but if the impairment has been brought about without any act of his own will, then, in my view, the offence created by s. 223 cannot be said to have been committed. . . .

It seems to me that it can be taken as a matter of "common experience" that the consumption of alcohol may produce intoxication and,

therefore, "impairment" in the sense in which the word is used in s. 223, and I think it is also similarly taken to be known that the use of narcotics may have the same effect, but if it appears that the impairment was produced as a result of using a drug in the form of medicine on a doctor's order or recommendation and that its effect was unknown to the patient, then the presumption is, in my view, rebutted.²⁵

The view that voluntary consumption of alcohol or drugs will satisfy the act and *mens rea* requirements of intoxicated and impaired driving has been criticized.²⁶ An addict's consumption of alcohol or drugs will always be voluntary within the narrow meaning I gave that word;²⁷ yet his consumption is not voluntary within the wide meaning of the word.

Other addiction-related crimes

Would the approach taken by the courts to act and *mens rea* in the intoxicated and impaired-driving situations be applicable to other addiction-related crimes? For example, could an accused escape conviction for causing a disturbance by being drunk in a public place¹ by proving he got drunk in his own home and later, when he was incapable of action or *mens rea*, caused a disturbance in a public place? I know of no case where such a defence was raised; if it were raised, it would likely be unsuccessful, on an analogy to the intoxicated and impaired-driving situations.

The offence of illegal possession of narcotics⁴ requires *mens rea* as well as an act. The voluntary consumption of narcotics does not in itself satisfy the act and *mens rea* requirements of that offence; the narcotic offence does not arise from the use of narcotics—as is the case with the main alcohol offences—but from their possession. A person who had never consumed narcotics could still be convicted of illegal possession.

Breathalyzer proposal

Not only are addiction, or the effects of alcohol or drugs if voluntarily produced, not defences to these addiction-related crimes, but a recent proposal²⁸ of the Executive Council of the

Canadian Bar Association threatens to affect alcoholic drivers adversely. The proposal is this:²⁹

The Canadian Bar Association recommends legislation as follows:

1. Making unlawful the driving of a motor vehicle by a person with a blood alcohol level to be fixed by the legislation provided,
 - (a) that the level should not be less than .08% or .8 parts per thousand of alcohol in venous blood,³⁰
 - (b) that the blood alcohol level be determined by analysis of breath only,
 - (c) that the accused is offered a sample of the material to be tested to determine the level,
 - (d) that the analysis on behalf of the Crown Prosecution is conducted by a duly qualified technician, and
 - (e) that the accused must be afforded the opportunity to cross-examine everyone who takes part in the taking of the sample and analysis of it including the person who is responsible for the maintenance of the equipment used in the analysis.
2. (a) Making it an offence for any person to refuse without cause to give a sample of breath when required to do so by any law enforcement officer who has reasonable and probable grounds for believing that such person has committed an offence.
 - (b) Making evidence of the test so conducted admissible upon the charge set out in 1. above or upon a charge of impaired or drunk driving.
3. That the offences recommended above be punishable on summary conviction only and that the penalties therefor shall be as for a first offence on impaired driving with no minimum penalty but with the power to prohibit driving on the highways in Canada during any period not exceeding three years.
4. That Section 222 and 223 of The Criminal Code be deleted and a new section enacted creating a new offence of impaired driving only.

“There are four commercially available types of apparatus which use samples of breath for the indirect analysis of alcohol in blood. . . . The Breathalyzer is the most suitable . . . for police work on the basis of reliability, accuracy, ease of operation and maintenance.”³¹ In Canada, in prosecutions under sections 222 and 223 of the Criminal Code for, respectively,

intoxicated and impaired driving, the Breathalyzer can be used only to corroborate other evidence. The reason why the Breathalyzer can be used only to corroborate other evidence is because of the potentially wide variance in effects of the same blood alcohol level in different persons. "The methods most commonly used in determining whether or not a person was intoxicated are an outgrowth of experience with drunken persons and are related to actions, conducts, and appearances, in short, to external manifestations."³²

Unfair to alcoholics?

The legislation proposed by the Executive Council of the Canadian Bar Association could be unfair to many alcoholics for this reason: heavy drinkers develop a high tolerance to alcohol and may not be noticeably intoxicated when the level of alcohol in their blood is much above .08 per cent. So long as Breathalyzer tests are used only to corroborate other evidence, the alcoholic who can meet the external tests will be exonerated, regardless of the concentration of alcohol in his blood.³³ The Canadian Bar Association proposal, however, is concerned only with blood alcohol levels; external manifestations of intoxication are irrelevant, except in so far as they may lead a police officer to request a sample of breath.

On the other hand, since alcoholic drivers are involved in a disproportionate number of accidents, there is something to be said for keeping all alcoholics off the roads, and the Canadian Bar Association proposal would tend to do that.

Addiction and other crimes

I have shown that neither addiction nor the effects of alcohol or drugs (unless they are produced involuntarily) are defences to addiction-related crimes. What of other crimes? Are addiction or the effects of alcohol or drugs ever defences in criminal law? As with addiction-related crimes, the *involuntarily*-produced effects of alcohol or drugs are defences to other crimes. Unlike addiction-related crimes, however, the *voluntarily*-produced ef-

fects of alcohol or drugs are in some circumstances defences to other crimes.

I have shown that with respect to many addiction-related crimes Canadian courts have satisfied the criminal-responsibility requirements of action and *mens rea* in an artificial way: by looking to the time when the accused consumed the alcohol or took the drug. If he did so, knowing he was consuming alcohol or taking a drug and knowing the probable effects, he will be considered to have satisfied the later addiction-related crime's requirements of action and *mens rea*. What of other crimes? Can an addict, under the influence of his addiction, escape criminal responsibility by showing he was incapable of action, i.e., he was an automaton at the relevant time? Or, failing this, can he argue that he was incapable of the necessary guilty mind?

Mens rea defence

So far as action is concerned, the answer seems to be the same as it is with respect to addiction-related crimes: the earlier voluntary intoxication will satisfy the act requirement of the later crime. So far as *mens rea* is concerned, intoxication, even though voluntary, may be a defence.

It is not every involuntary act which leads to a complete acquittal. Take . . . an involuntary act which proceeds from a state of drunkenness. If the drunken man is so drunk that he does not know what he is doing, he has a defence to any charge, such as murder . . . in which a specific intent is essential, but he is still liable to be convicted of manslaughter . . . for which no specific intent is necessary. . . .³⁴

What is a specific intent in this context?

In considering the question of *mens rea*, a distinction is to be drawn between "intention" as applied to acts done to achieve an immediate end on the one hand and acts done with the specific and ulterior motive and intention of furthering or achieving an illegal object on the other hand. Illegal acts of the former kind are done "intentionally" in the sense that they are not done by accident or through honest mistake, but acts of the latter kind are the product of preconception and are deliberate steps taken

towards an illegal goal. The former acts may be the purely physical products of momentary passion, whereas the latter involve the mental process of formulating a specific intent. A man, far advanced in drink, may intentionally strike his fellow in the former sense at a time when his mind is so befogged with liquor as to be unable to formulate a specific intent in the latter sense.³⁵

Despite Lord Denning's contrary view,³⁴ the better opinion is that voluntary intoxication can be a defence to all crimes requiring *mens rea*³⁶ except those related to addiction. There is, however, a reluctance to give effect to the defence and it has seldom been successful.³⁷

The reluctance to give effect to the defence of intoxication, and the attempt to restrict it to certain kinds of *mens rea*, are no doubt related to the accused's voluntary intoxication. There appears to be a judicial feeling, often unexpressed and no doubt a reflection of a general societal point of view, that in many cases it would be unjust for the accused, whether addict or not, to escape full criminal responsibility as a result of a self-induced condition.

Legal insanity

Some addicts, in advanced stages of their addiction, may escape criminal responsibility on the basis of legal insanity.³⁸ I am thinking particularly of *delirium tremens*,³⁹ a disorder found in certain chronic alcoholics, usually revealing itself during withdrawal from alcohol.⁴⁰

But drunkenness is one thing and the diseases to which drunkenness leads are different things; and if a man by drunkenness brings on a state of disease which causes such a degree of madness, even for a time, which would have relieved him from responsibility if it had been caused in any other way, then he would not be criminally responsible. In my opinion, in such a case the man is a madman, and is to be treated as such, although his madness is only temporary. If you think he was so insane — that if his insanity had been produced by other causes he would not be responsible for his actions — then the mere fact that it was caused by drunkenness will not prevent it having the effect which otherwise it would have had,

of excusing him from punishment. Drunkenness is no excuse, but *delirium tremens* caused by drunkenness may be an excuse if you think it produces such a state of mind as would otherwise relieve him from responsibility.⁴¹

Legal insanity is, of course, a defence to any crime, including the addiction-related crimes. However, it is usually raised as a defence to capital crimes only, because, although it leads to a verdict of not guilty by reason of insanity, it results in indefinite incarceration in a mental institution.⁴²

Treatment of Addicts

No sure cure for addiction, whether to alcohol or to drugs, has yet been found.

I have shown that addiction *per se* is not a defence to crime, although the effects of alcohol or drugs may be defences in certain circumstances. The consensus of enlightened opinion is that addiction is a disease. This being the case, one would suppose that, in sentencing addicts, the federal penal system would provide for compulsory medical treatment.

Generally speaking, medical treatment is not provided for imprisoned alcoholics, whether convicted of alcohol-related, or other, crimes.⁴³ There are no treatment centres for alcoholics under the federal penal system.

At present, there are no medical treatment centres for drug addicts under the federal penal system. However, Part II of the Narcotic Control Act—not yet proclaimed in force—takes a new approach to narcotic drug addiction. The proclamation of this part of the Act presumably will follow the completion of the pioneer federal narcotic addiction treatment institution at Matsqui, British Columbia.⁴⁴

In addition to repealing the Opium and Narcotic Drug Act, which was Canada's basic legislation in the area for over 40 years, the new statute [the Narcotic Control Act] separates criminal enforcement from legal distribution aspects, introduces new offences and stiffer penalties, and, most significantly, substitutes for mere imprisonment the idea of committing addicts to custody for treatment in special centres. . . .

It is in Part II of the statute that the sweep of the new policy reveals itself. . . . Section 16 provides that where a person is charged under sections 3, 4, or 5, the court may, upon application by the Crown or the person charged or his counsel, either before or after he is committed for trial and before any sentence is passed, remand him to custody for examination for not more than seven days. And, under section 17(1) where the person who has been so remanded is convicted, the court must, before sentencing him, consider the evidence from the examination, together with medical evidence, and if the court is satisfied that he is a narcotic addict, it must . . . sentence him to custody for treatment for an indeterminate period in lieu of any other sentence for the offence of which he was convicted. It is here that one sees, for the first time, that federal legislation recognizes addicts as patients, that it regards addiction as something more complex than criminal indulgence, and that it abandons the threadbare belief in the efficacy of punishment simpliciter. . . . Where a person is sentenced to custody for treatment for an indeterminate period, he will be placed, under section 18, in an institution operated under the Penitentiary Act and become subject to the Parole Act. If he has not previously been convicted under the narcotic statute, the length of his sentence for treatment is fixed by the Parole Board, but cannot exceed 10 years from the time of his parole, unless before then his parole is forfeited or revoked. Parole, however, is only permitted when the board says that it is in the interest of society to release the inmate. . . .

An advanced statute

These are wholly new departures from the old program. How they will work out in practice remains to be seen. For some addicts the new plan will mean a life-time of medical care. The government, however, has nowhere suggested that treatment facilities alone can beat the addiction problem. Its spokesmen have underscored the need for a positive attitude on the part of the addict himself, the importance of after-care, rehabilitation, job opportunities, subsequent assimilation into society, and so forth. The new scheme takes into account many more relevant factors than the old one did, and it is hard to resist the conclusion that, all in all, it is one of the more advanced statutes of its kind in the world today.

All is not rosy, however. . . . The pioneer treatment centre at Matsqui, British Columbia, has all the earmarks of being another Lexington.⁴⁵

The treatment provisions of the Narcotic Control Act apply

only to those convicted of narcotic offences. For example, they do not apply to a narcotic addict charged with theft, even though he stole to support his habit: such an addict goes to an ordinary prison, if convicted. Why is this distinction drawn between, for instance, the addict who traffics in narcotics to support his habit, and the addict who steals for the same reason? I do not believe this question can be answered satisfactorily. The reason for the distinction is, no doubt, partly an administrative one: since, presumably, a much smaller percentage of those who steal are narcotic addicts than are those who traffic in narcotics, it might be difficult to discover those thieves who were also narcotic addicts. In addition, one can argue that a narcotic addict, no matter how he finances his habit, will eventually be caught and charged with illegal possession of narcotics under the Narcotic Control Act, and will then receive treatment for his addiction. Nevertheless, one would hope that this distinction eventually will disappear, and that every criminal addict, regardless of his crime, will receive compulsory medical treatment for his addiction in lieu of, or in addition to, punishment.

Treatment by the provinces

Apart from treatment connected with criminal law, under the British North America Act, the treatment of addiction is a provincial matter. "This division of power must be kept in mind when considering solutions, and one must avoid the all too common error of recommending that the federal government do something which is beyond its legislative reach."⁴⁶

Many Canadian provinces have enacted legislation providing for the treatment of those alcoholics who voluntarily seek it.⁴⁷

Ontario was the first province in Canada to establish an official organization for the express purpose of finding out, through a research program, how best to deal with the problem of alcohol addiction. It was in 1949 that an Act of the Ontario Legislature brought the Alcoholism Research Foundation into existence. . . .

Active work by the Foundation began in 1950. During the 14 years since then it has: [among other activities] . . . Set up in separate Ontario

cities eight alcoholism clinics which have, cumulatively over a period of years, provided treatment services for several thousand alcoholics. . . .⁴⁸

The most important and perhaps the most successful agency now active in the treatment of alcoholics is Alcoholics Anonymous. It is futile to ask what percent of alcoholics who are introduced to A.A. achieve sobriety through the services. Reliable figures are not available. . . . Most [alcoholism] clinics take great pains to foster contacts by A.A. with their patients. Some patients do well in A.A., others will have nothing to do with it. Refusal to accept A.A. does not necessarily mean that the patient will not achieve sobriety. A.A. is not only a recipient of patients from clinics but also an important source of referrals.

There is no quick and certain treatment for alcoholism.⁴⁹

Only a small percentage of alcoholics voluntarily seek help. As a result, compulsory treatment for certain difficult alcoholics has been urged from time to time. "In each province there is . . . some provision to deal with alcoholic patients in the mental-hospital system."⁵⁰ For example, in Ontario there are provisions in the Mental Hospitals Act⁵¹ for the compulsory committal and treatment of alcoholics whose behaviour satisfies certain conditions.⁵² For a number of reasons these provisions have been little used.⁵³ In addition to the compulsory provisions of the Mental Hospitals Act, in Ontario a person convicted for the third time in a period of twelve months of being intoxicated in a public place⁵⁴ "where it appears that he may benefit therefrom, . . . may be ordered to be detained for a term of ninety days in an institution for the reclamation of alcoholics."⁵⁵

Treatment of drug addicts

"Treatment facilities for non-criminal . . . [drug] addicts are meagre in North America."⁵⁶ "During 1961, the [Ontario Alcoholism Research] Foundation was renamed The Alcoholism and Drug Addiction Research Foundation and its terms of reference were broadened accordingly."⁵⁷ In 1964, 207 voluntary patients were treated for drug addiction at the Ontario Foundation's Narcotic Addiction Unit in Toronto.⁵⁸

Other forms of voluntary treatment of drug addicts include

Narcotics Anonymous (similar to Alcoholics Anonymous), and what has been called the British system.

The British control system looks upon drug addiction as a medical problem and keeps it primarily in the hands of the physician. The decision whether to give regular prescriptions to the English user is left to the doctor, usually after consultation with another medical man. He does not have to report addicts under his care but records must be kept both by him and by the druggists who fill the prescriptions. The British system applies pressure on the doctor to persuade the addict to accept treatment for cure of his addiction but allows doctors to prescribe sustaining doses of narcotics for habitual users. As a result under the drug act addicts can obtain narcotics by prescription for 14 cents which takes away practically all incentive to secure drugs from illegal sources.⁵⁹

The British approach to the treatment of drug addiction has not been tried in Canada; there is nothing in Canadian law, however, which would prevent the application of at least certain aspects of that approach.⁶⁰

The above remarks concerning the non-penal treatment of drug addicts are referrable to those addicts who voluntarily seek treatment. The provisions of the Ontario Mental Hospitals Act⁶¹ for the compulsory committal and treatment of alcoholics apply as well to drug addicts.

Notes

¹"Every one who (a) not being in a dwelling house causes a disturbance in or near a public place . . . (ii) by being drunk . . . is guilty of an offence punishable on summary conviction."—*Criminal Code*, S.C. 1953-54, c. 51, s. 160(a)(ii). By section 694(1) of the Code, the maximum penalty for a summary-conviction offence under the Code ("except where otherwise expressly provided") is five hundred dollars and six months' imprisonment.

Many provinces have similar provisions. For example, *The Liquor Control Act*, R.S.O. 1960, c. 217, s. 80(2): "No person shall be in an intoxicated condition in a public place." By section 106(7) of this Act, as amended by S.O. 1960-61, c. 47, s. 1 and S.O. 1961-62, c. 72, s. 4, the maximum penalty for a first offender is fifty dollars, and for a person who offends three times within a twelve-month period, thirty

days' imprisonment. As an alternative to either of these penalties, the offender may be detained in an institution for the reclamation of alcoholics.

²"Every one who, while intoxicated or under the influence of a narcotic drug, drives a motor vehicle or has the care or control of a motor vehicle, whether it is in motion or not, is guilty of (a) an indictable offence and is liable (i) for a first offence, to imprisonment for not more than three months and not less than thirty days, and (ii) for each subsequent offence, to imprisonment for not more than one year and not less than three months; or (b) an offence punishable on summary conviction and is liable (i) for a first offence, to imprisonment for not more than thirty days and not less than seven days, (ii) for a second offence, to imprisonment for not more than three months and not less than one month, and (iii) for each subsequent offence, to imprisonment for not more than one year and not less than three months."—*Criminal Code*, s. 222.

³"Every one who, while his ability to drive a motor vehicle is impaired by alcohol or a drug, drives a motor vehicle or has the care or control of a motor vehicle, whether it is in motion or not, is guilty of an indictable offence or an offence punishable on summary conviction and is liable (a) for a first offence, to a fine of not more than five hundred dollars and not less than fifty dollars or to imprisonment for three months or to both, (b) for a second offence, to imprisonment for not more than three months and not less than fourteen days, and (c) for each subsequent offence, to imprisonment for not more than one year and not less than three months."—*Criminal Code*, s. 223.

Section 222 of the Code refers to a narcotic drug, while section 223 refers simply to a drug. Presumably, a person under the influence of barbiturates, tranquillizers or amphetamines could not be charged under section 222. In view of the potential effects of these non-narcotic drugs, particularly barbiturates and amphetamines, this seems strange.

These two sections create two distinct offences: driving a motor vehicle while intoxicated or impaired, and having the care or control of a motor vehicle while intoxicated or impaired. There might be sufficient evidence to convict of having the care or control, but not to convict of driving.

By virtue of section 225 of the Code, the court, as an additional penalty for a conviction under sections 222 or 223, may prohibit the accused from driving in Canada for up to three years. Some provinces

provide for the automatic suspension or cancellation of drivers' licences of those convicted under sections 222 and 223.

⁴“(1) Except as authorized by this Act or the regulations, no person shall have a narcotic in his possession. (2) Every person who violates subsection (1) is guilty of an indictable offence and is liable to imprisonment for seven years.”—*Narcotic Control Act*, S.C. 1961, 9-10 Eliz. II, c. 35, s. 3.

It is interesting to compare the severity of the possible penalty under the Narcotic Control Act for illegal possession of narcotics with the relatively light penalties under the Criminal Code for public drunkenness and intoxicated and impaired driving.

⁵Howe, “An Alternative Solution to the Narcotics Problem” (1957), 22 *Law and Contemp. Prob.* 132, at p. 133.

⁶Ryan, “The Adult Court,” in *Crime and Its Treatment in Canada* (1965), pp. 136, 137, 144.

⁷A failure to act is a crime in those rare situations where the criminal law imposes a duty to act. For example, section 186 of the Criminal Code imposes a duty on parents to provide their children with the necessities of life. See generally on duties of action in criminal law Williams, *Criminal Law* (2nd ed., 1961), ss. 3, 4, hereinafter cited as Williams.

⁸Except for those situations where there is a duty to act.

⁹Halsbury's *Laws of England* (3rd ed. 1955), 10, pp. 273-274. But see Williams, pp. 31, 102-103, who suggests that negligence, no matter of how high a degree, should not be regarded as a form of *mens rea*.

¹⁰Unless you are an Indian: Section 94(b) of the *Indian Act*, R.S.C. 1952, c. 149, makes it an offence for an Indian to be intoxicated off a reserve.

¹¹*Criminal Code*, s. 160(a)(ii). For the provisions of this section see note 1 above. Alcohol probably plays an important role in a large percentage of the convictions for vagrancy under section 164 of the Code.

¹²*Narcotic Control Act*, s. 3. For the provisions of this section see note 4 above. The other offences under the Narcotic Control Act are trafficking in narcotics (s. 4(1)), possession for the purpose of trafficking (s. 4(2)), importation (s. 5), and cultivation of opium poppy or marihuana (s. 6).

¹³*Statistics of Criminal and Other Offences*, Dominion Bureau of Statistics (Queen's Printer, 1965).

In addition to the convictions under the Criminal Code for causing

a disturbance by being drunk in a public place, there were in 1962 101,650 convictions for intoxication under provincial statutes, and 16,316 convictions for intoxication under municipal by-laws. There were also 6,711 convictions for vagrancy under the Code in 1962.—*Ibid.*

In addition to the convictions under the Narcotic Control Act for illegal possession of narcotics, there were in 1962, under that Act, 53 convictions for trafficking, 16 convictions for possession for the purpose of trafficking, and 1 conviction for importation.—*Ibid.*

¹⁴(1962), 40 W.W.R. 244 (Sask. C.A.).

¹⁵For the provisions of this section see note 2 above. The actual charge in the *McCormick* case was having the care or control of a motor vehicle while intoxicated.

¹⁶*Regina v. McCormick* (see note 14 above), at p. 245 (from the agreed statement of facts).

¹⁷*The Queen v. King*, (1962) S.C.R. 746 (Taschereau, Locke, Martland, Judson and Ritchie JJ.).

¹⁸For the provisions of this section see note 3 above. The actual charge in the *King* case, unlike that in the *McCormick* case (see note 15 above), was driving a motor vehicle while impaired.

¹⁹*The Queen v. King* (see note 17 above), at p. 756 (*per* Ritchie J.).

²⁰*Regina v. King*, (1961) O.W.N. 37 (Porter C.J.O. and Schroeder J.A.; MacKay J.A. dissenting).

²¹For himself and Martland J., Taschereau J. being in substantial agreement.

²²*The Queen v. King* (see note 17 above), at p. 757.

²³*Ibid.*, at p. 764.

²⁴See Taschereau J., *ibid.*, at pp. 749-750; Ritchie J., *ibid.*, at p. 762.

²⁵*Ibid.*, at pp. 763, 764.

²⁶"It is clear from Schroeder, J.A.'s judgment [*Regina v. King* in the Ontario Court of Appeal, note 20 above] that the crux of the matter to his mind was the issue whether any moral fault could be attributed to the appellant in the circumstances before the court. As he put it: 'If there were fault or negligence on the part of an accused driver in failing to appreciate that the use of the drug would incapacitate him at the material time then such fault or negligence on his part might supply the element of criminal intent but that view cannot be taken on the facts in this case.' This approach represents a departure from the basic elements constituting voluntary conduct, namely volition and consciousness.

In viewing the crucial question as being concerned not with the absence of volition or consciousness *per se* at the time of the actual commission of the offence but rather as having to be judged according to the broad standards of moral fault based on negligence, the learned justices, with respect, erred in their interpretation of this basic principle of criminal liability.”—Edwards, “Automatism and Social Defence.” (This paper was delivered by Professor Edwards at a postgraduate course in forensic psychiatry conducted by the Division of Postgraduate Medical Education of the Faculty of Medicine of the University of Toronto in March, 1964, and was published beginning at p. 35 of a mimeographed volume of the course papers.)

As the quoted passage indicates, Prof. Edwards believes that the defence of automatism is wider than the defence of no act. He believes that the defence of automatism is available where the accused, though capable of action, is incapable of controlling that action. See also Edwards, “Automatism and Criminal Responsibility,” in the papers of the same course.

²⁷Apart from cases like *The Queen v. King*, it is difficult to imagine an involuntary consumption of alcohol or drugs. Cf. Prosser, *Torts* (3rd ed., 1964) p. 157, n. 42: “The cases all say that involuntary, non-negligent intoxication, as where the old lady who never had tasted whiskey is given a cup of ‘tea,’ is to be treated like illness or physical disability. No cases, however, have been found—quite possibly because it simply does not happen.”

²⁸This proposal, together with the report of a Special Committee of the Canadian Bar Association, are set out in “Blood Alcohol and Traffic Accidents” (1965), 8 *Can. B.J.* 70.

²⁹“Blood Alcohol and Traffic Accidents” (see note 28), at pp. 70-71.

³⁰“A level reached by a 160-pound man after drinking 4½ ounces of liquor or three pints of beer.”—*Toronto Daily Star*, Sept. 2, 1965.

³¹Smith and Lucas, “Breath Tests for Alcohol” (1958), 1 *Crim. L.Q.* 25.

³²Smart and Schmidt, “Review Present State of Knowledge on Alcohol, Alcoholism and Driving,” *ALCOHOLISM* 5, 4 (December, 1958) 17, at pp. 18-19. (*ALCOHOLISM* was the former name of *ADDICTIONS*.) There is no obligation on an accused to perform physical tests for the police, and evidence of his refusal to do so is inadmissible at his trial. Similarly, by virtue of section 224(4) of the Criminal Code, an accused is not obliged to take a Breathalyzer test, and evidence of his refusal to do so is inadmissible at his trial.

³³As was the accused in *Regina v. Lord*, (1958) O.R. 193 (Stewart J.),

despite a Breathalyzer reading of .16 per cent.

³⁴*Bratty v. Attorney-General for Northern Ireland*, (1963) A.C. 386, at p. 410 (*per* Lord Denning).

It has been suggested that a high degree of negligence is sufficient to sustain a conviction for manslaughter. (See note 9 above).

³⁵*The Queen v. George*, (1960) S.C.R. 871, at p. 890 (*per* Ritchie J.). But see Williams, p. 49.

"When it is said that given crimes need intention, what is referred to is intention as to consequence."—*Ibid.*, p. 52. On *mens rea* generally see *ibid.*, ch. 2.

³⁶Williams, pp. 568, 569, 571: "If the crime requires intention, drunkenness may help to show that there was no desire of the consequence; if it requires recklessness, drunkenness may help to show that there was no foresight; drunkenness may also help to negative knowledge or establish mistake. In short, drunkenness is a matter to be taken into consideration in deducing intent or recklessness from outward acts. There is no special rule here, except that the fact of drunkenness is admissible in evidence. . . . These propositions, true for alcoholic intoxication, are, of course, just as applicable to other drugs. . . . It is not the drunkenness that is a defence; drunkenness is no defence; it is simply a piece of evidence relevant to infer that a necessary mental state was absent."

Whether intoxication can be a defence to rape under section 135 of the Criminal Code is unclear: *Regina v. Boucher* (1962), 40 W.W.R. 663 (B.L.C.A.), said it cannot; *Regina v. Vandervoort* (1961) O.W.N. 141 (C.A.), said it can. The Supreme Court of Canada has not dealt with the problem. Although I believe the *Vandervoort* conclusion is correct, it depended (in my view unnecessarily) on a finding that rape requires a specific intent. See Williams, p. 569.

The Supreme Court of Canada has recently held that intoxication is relevant in deciding whether murder will be reduced to manslaughter because of provocation under section 203 of the Criminal Code: *Salamon v. The Queen* (1959), 123 C.C.C. 1 (intoxication material on the issue of whether the accused was provoked in fact), and whether murder is capital or non-capital under section 202A of the Code: *Regina v. Mitchell* (1964), 43 C.R. 391 (intoxication material on the issue of whether the murder was planned and deliberate), and in assessing the value of a confession: *Rustad v. The Queen*, (1965) S.C.R. 555 (intoxication material on the issue of the truthfulness of the accused's confession of homicide to friends).

Intoxication is not a defence where the accused gets drunk in order to commit a crime, assuming he had the requisite *mens rea* before he got drunk: *Attorney-General for Northern Ireland v. Gallagher*, (1961) 3 A11 E.R. 299 at p. 314 (H.L. *per* Lord Denning); Williams, p. 571.

³⁷*Cf.* Note (1928), 6 *Can. Bar Rev.* 162, at p. 166: "It may be said that though the defence is sound in law, that the facts necessary to support it rarely exist, and when they do, are frequently not susceptible of proof. The crux of the matter is the degree of drunkenness and it appears to be invariably difficult to prove that at the [relevant] time . . . the accused had reached that state of drunkenness recognized by law as negating intent."

Although the onus is on the accused to introduce some evidence of intoxication, he does not have the burden of establishing that because of intoxication he was incapable of the required *mens rea*: *Broadhurst v. The Queen* (1964) A.C. 441, at p. 461 (P.C. *per* Lord Devlin); *Regina v. Hilson*, (1958) O.R. 665 (C.A.); Williams, pp. 571-572.

³⁸*Criminal Code*, s. 16. See generally Williams, s. 179.

³⁹**"Delirium Tremens.** A disorder of the nervous system, involving the brain and setting up an attack of temporary delusional insanity, sometimes attended with violent excitement or mania, caused by excessive and long continued indulgence in alcoholic liquors, or by the abrupt cessation of such use after a protracted debauch."—*Black's Law Dictionary* (4th ed., 1951), p. 515.

⁴⁰Withdrawal from barbiturates may produce a similar condition: see S. J. Holmes, "Barbiturates—Friend or Foe?" *ADDICTIONS* 9, 4 (Spring, 1963) 25, at p. 26.

⁴¹*Regina v. Davis* (1881), 14 *Cox Crim. Cas.* 563, at p. 564 (Stephen J. in his charge to the jury). The accused had previously been drinking heavily but was sober at the relevant time.

⁴²*Criminal Code*, ss. 523, 526.

⁴³But see Armstrong and Turner, "Special Problem Groups: Alcoholics, Drug Addicts, Sex Offenders" (hereinafter cited as Armstrong and Turner), in *Crime and Its Treatment in Canada* (1965), pp. 435-436: "In Ontario, the Alex G. Brown Clinic in the Mimico Reformatory has been operated by the Department of Reform Institutions for some years to provide treatment for alcoholic prisoners, but it can accommodate only a small number of those presumed to have alcohol problems. . . . In Alberta, as in Ontario, there is a unit in the reformatory system . . . devoted to providing a short-term treatment program for

individuals sentenced to the provincial reformatory and found to be suffering from alcoholism."

"A person who is convicted of crime and sentenced to imprisonment for a period of two years or more is ordinarily sent to a penitentiary, a federal institution. If the sentence imposed is for a period of less than two years, the usual place of confinement would be a reformatory, a provincial institution."—Swadron, *Detention of the Mentally Disordered* (1964), p. 251.

Although medical treatment is not provided for imprisoned alcoholics, except as noted above, "the increasing number of public clinics throughout Canada devoted to the treatment of alcoholism . . . provides the courts with some latitude . . . in determining the sentence of those in whose offences alcohol has played some role. Treatment may be included as a condition of probation with some hope that such treatment will be available in the community."—Armstrong and Turner, p. 436.

⁴⁴This institution opened officially in July, 1966, but the first prisoners had been moved in early in March.

⁴⁵Macdonald, "Narcotics, Addicts and the Law," *ADDICTIONS* 11, 1 (Summer, 1964) 18, at pp. 21, 26, 27, 28, 29-30.

"It would appear that the experience of the United States . . . at the Lexington and Fort Worth hospitals has been very disappointing. A relapse rate of some 90 per cent has been reported."—S. J. Holmes, "Narcotic Addiction: Some Thoughts on Present Programs and Future Needs," *ADDICTIONS* 9, 3 (Winter, 1962) 10, at p. 13.

For an excellent description of the narcotic law in Canada prior to the Narcotic Control Act see Macdonald, "Narcotic Drug Addiction in Canada" (1960), 1 *Cur. Law and Soc. Prob.* 162, pp. 168-192.

⁴⁶Macdonald, "Narcotic Drug Addiction in Canada" (see note 45), p. 201.

⁴⁷"In all Canadian provinces except New Brunswick and Newfoundland, governmental agencies are now established to determine the need for treatment, research, and education in the field of alcoholism, and to recommend or implement policies respecting their provision. Under the auspices of these agencies, treatment facilities are available in British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario."—Armstrong and Turner, p. 436.

⁴⁸Fourteenth Annual Report of the Foundation (1964), p. 5.

For a description of the treatment procedures followed in alcoholism clinics see Armstrong and Turner, pp. 438-440.

- ⁴⁹Ferguson, "Alcoholism As a Public Health Problem," *ALCOHOLISM* 4, 1 (November, 1956) 3, at p. 8.
- ⁵⁰Armstrong and Turner, p. 437.
- ⁵¹R.S.O. 1960, c. 236, ss. 1(f), 49-54. These provisions apply to drug addicts as well.
- ⁵²*Ibid.*, s. 50.
- ⁵³In 1956 there were only 157 alcoholics and drug addicts receiving compulsory treatment under the Ontario Mental Hospitals Act.—"New Law For Compulsory Treatment Proposed by Medico-Legal Society," *ALCOHOLISM* 5, 4 (December, 1958) 9.
- ⁵⁴*The Liquor Control Act*, R.S.O. 1960, c. 217, s. 80(2).
- ⁵⁵*Ibid.*, s. 106(7)(c), as amended by S.O. 1960-61, c. 47, s. 1, and S.O. 1961-62, c. 72, s. 4.
- "One additional institution of approximately 125 beds . . . has already been opened to meet the needs created by this legislation."—Armstrong and Turner, p. 436.
- In addition, under their reformatory systems both Ontario and Alberta provide medical treatment for some alcoholic prisoners; see note 43 above.
- ⁵⁶"First Decade Points Way to Future for Addiction Research Foundation," *ADDICTIONS* 8, 4 (Spring, 1962) 20.
- ⁵⁷Fourteenth Annual Report (see note 48), page 5. British Columbia has a similar foundation.
- ⁵⁸*Ibid.*, pp. 14-15. Considering that Ontario has an estimated 11,000 drug addicts (*ibid.*, p. 9), this is a small number of voluntary patients.
- ⁵⁹S. J. Holmes, "Medical Profession Seen as Leader in Combatting Narcotics Addiction," *ADDICTIONS* 8, 2 (Autumn, 1961) 11, at p. 12.
- See generally on the British system Frankau, "Canadian Narcotic Addicts in England," *ADDICTIONS* 11, 1 (Summer, 1964) 47; Lindesmith, "The British System of Narcotic Control," (1957) 22 *Law and Contemp. Prob.* 138; Macdonald, "Narcotic Drug Addiction in Canada" (see note 45), pp. 193-195.
- ⁶⁰See Macdonald, "Narcotics, Addicts and the Law" (see note 45), pp. 31-32.
- ⁶¹R.S.O. 1960, c. 236, ss. 1 (f), 49-54. In Ontario, as is the case with alcohol (see note 43), there is a small drug addiction clinic at the Mimico Reformatory. See S. J. Holmes, *op. cit.* (see note 59), at p. 46. Treatment is on a voluntary basis.—*Ibid.*, at p. 51.

Legislation to Control Addiction

by Robert F. Reid, Q.C.

It is a striking fact that in spite of the dozens of offences resulting from addiction in the laws of Canada, no one has ever been sent to jail, or had his legal status even slightly impaired, *simply* because he was an addict.

If the addict to alcohol becomes intoxicated in public he may be charged with public drunkenness, and he may be fined or jailed. If he stays in his own home and drinks himself quietly to death, no law can touch him — unless he becomes mentally incompetent or completely incapable of managing his affairs. In the latter cases, he *might* be sent off to a mental hospital by court order — not because he is an addict, but because he is a lunatic or near-lunatic. The drug addict is immune from the law unless he is a trafficker, or has a drug in his possession, or is guilty of some such act. The mere fact of being an addict or of consuming a drug does not expose him to any penalty, civil or criminal.

Present laws inadequate

Thus the laws we have to control addiction hit only at the fringes, not at the heart, of the problem. All they do is attempt to stop certain kinds of behaviour, mostly public, that might or might not be related to addiction. Such behaviour — public drunkenness, for instance — might equally be engaged in by the non-addict. The consequence provided by the law is not treatment, but a jail term or some other penalty. If we imagine that such laws actually control addiction — in the sense of preventing it, regulating it and curing it, we are fooling ourselves.

This is probably because the laws that we have in order to control addiction do not really recognize the problem of addiction. In fact, our present concept of addiction was unknown

Mr. Reid is counsel to this Foundation. He prepared this paper for delivery to a Foundation working conference on this subject, involving Foundation staff and outside consultants, in Toronto November 30, 1966.

when most of our laws were written. We now think of addiction as an appetite beyond the power of the individual to control. Satisfying his addiction is not an act of will on the addict's part—it is an act of necessity. In this sense it is an involuntary act, which will occur in spite of the firmest resolve against it. The result is that we charge an alcoholic with public intoxication and send him to jail to punish him. Punish him for what? For doing something he cannot stop himself from doing. Do we help him to stop? Only by sending him to jail for a few days, weeks or months and leaving him there—without treatment, understanding or concern. How effective is this curious program? It keeps the addict off the streets for a little while; that is all.

The addict can't stop himself

This is like sending an itchy man to jail for scratching, or convicting a man in the desert of the crime of drinking water. If our present concept of addiction is accurate, the addict can no more stop himself from drinking alcohol than the man in the desert can from drinking water.

By and large, our laws ignore the nature of addiction. Creating an offence, charging a person with it, trying, convicting and jailing him for it—these things make sense only on the assumption that he can exercise his own free will in the matter and that if he wants to avoid the penalty he will not engage in the act. If a man wishes to avoid parking tickets, he can choose not to park illegally. If he wishes to avoid jail, he can decide not to beat up his neighbours. The prospect of these penalties deters the man who is in control of his actions. But if he has no free will in the matter, and if the object of the process is prevention, then the process is senseless.

The explanation of this paradox is not far to seek. Leaving aside the excellent legislation that has created agencies to study the problem of addiction, such as Ontario's Alcoholism and Drug Addiction Research Foundation, the laws affecting addiction were for the most part written before the modern concept

of addiction came into being. Addiction was formerly thought to be simply the result of moral weakness. It was thought that resort to the bottle could and should be cured by sterner self-discipline. One could strengthen one's resolve; if this should fail, the bleak prospect of jail ought to do the trick. And so, laws were enacted with this in mind: to deter the weak or the vacillating from conduct that was publicly odious and personally harmful. It was assumed that everyone had a free choice. It is only recently that we have come to the view that, left to himself, the addict does not really have a free choice at all.

Punishment no deterrent

Today's rising demand for more humane and sensible laws to deal with addiction arises out of the contradiction between the law and the problem. It is false to assume that an addict is capable of deciding not to consume heroin or drink alcohol. Hence, attempts to deter him by punishment are senseless. The result is a general restiveness on the part of many people with our present laws, and a conviction that they must go, holus-bolus.

In its way, this attitude is no more sensible than the contrary view that the laws must stay as they are. There is undoubted merit in some of our present laws relating to addictions, even though they fail to touch the heart of the problem. Drug trafficking is a social evil and must be controlled without hesitation or remorse; repealing the Narcotic Control Act because it does not recognize the real nature of addiction is like throwing out the baby with the bath water. Public drunkenness is a social problem, even when engaged in by non-alcoholics. A case can be made for retaining the present law against public drunkenness, merely to serve public decency and order. Simply because the present law fails to discriminate between the alcoholic, who cannot stop himself, and the mickey-toting football fan, who can, is no reason to throw out the law completely. The college boy who suddenly finds himself free of the restrictions of home and who passes out on the street after a fraternity

stag party is just as much a problem of public order as the skid-row drunk who can't make it back to his flophouse.

What is needed is some change in the law, taking the facts of addiction into account, and an attempt to do something constructive about it. It is a fact that no alcoholic was ever cured by thirty days in jail. It is a fact that sending him to jail because he gets drunk in public is a waste of everyone's time, including his. It is a fact that he is just as likely to get drunk after he gets out as he was before he went in. It is a fact that sending an alcohol or drug addict to jail without treatment is senseless and inhumane and exposes him, as it would any sick man, to cruel and unusual punishment.

We do not send people to jail for lunacy any more. We do not send them to jail for cancer or arthritis. To do so would be cruel. Why should we send the addict? It is possible that he is no more responsible for his condition than the man with a bad heart or flat feet. It is also possible that jail will do no more to alleviate his condition than it would a bad heart or flat feet.

Recognize involuntary act

Hence, there should be some recognition in our laws of the involuntary act — the act of the addict. Since it is now generally accepted that bread and water have failed and that medicine might cure, the addict should be given treatment in place of punishment. This belief is reflected in the recent decisions of American courts that have refused to send chronic alcoholics to jail for public drunkenness. Jail in these circumstances has been held to be "cruel and unusual punishment" and contrary to the constitutions of the United States and of many States, which contain positive guarantees against it. This is the basis for the celebrated *Driver* decision in 1965.¹

In the equally celebrated *Easter* case, decided early this year, an American appellate court relied on the common-law principle that an act can be criminal only where it is voluntary, and ruled that the act of a chronic alcoholic in becoming intoxi-

cated does not support a conviction for public drunkenness.²

These two decisions could exempt chronic alcoholics completely from the offence of public drunkenness and could make the much-deplored "revolving door" disappear. Since we are told that alcoholics form the major proportion of those charged with public drunkenness, the effect should be extensive.

Trouble with U.S. decisions

The trouble with this change in the handling of the street alcoholic, which should otherwise be applauded, is that it simply returns him to skid row. It does not send him off for treatment in a hospital or rehabilitation centre — it simply keeps him out of jail. Keeping him out of jail may be more humane, but it does nothing to cure his alcoholism. Indeed, in bitter weather he might be better off in jail — he will at least be warm and fed. If this is to be the consequence of enlightened concern, we might have cause to regret it.

Could the *Driver* or *Easter* defences succeed here? We have the offence of public drunkenness in Ontario and elsewhere, but the basis for the *Driver* defence does not exist: there is no constitutional guarantee against "cruel and unusual punishment" that applies. The Canadian Bill of Rights does contain a guarantee against "cruel and unusual treatment or punishment,"³ but it does not apply to offences under provincial laws, and public drunkenness is an offence under provincial laws.

The *Easter* concept has a better chance of succeeding. Canadian criminal law recognizes the principle of *mens rea* — that is, that some conduct, to be criminal, must involve a guilty mind. *Mens rea* is not a necessary ingredient of all offences: where the object of the prohibition is to exclude a thing absolutely, *mens rea* need not be proven — as in, for instance, the Defence of Canada Regulations, which were made to protect the country in time of war. Whether *mens rea* is necessary depends on the nature of the offence: for instance, the offence of manslaughter does not require proof of intent to kill; in fact,

it is the lack of such intent that distinguishes that crime from murder.

Inability to form an intent, therefore, can be a defence, or at least a partial defence. This is how drunkenness may become a defence: if the accused is too drunk to form an intent, and intent is a necessary ingredient of the offence, he is not guilty of the offence. The result might be only partial consolation: for instance, a charge of murder might be reduced in this way to one of manslaughter, which can still be punished by imprisonment for life.

Canadian courts have shown some reluctance to recognize the defence of drunkenness as removing the element of *mens rea* in offences involving alcohol. "Drunk-driving" cases illustrate this: if the consumption of alcohol was voluntary to begin with, the court is unlikely to excuse the accused simply because he drank so much that he did not know what he was doing.

To plead drunkenness as a defence to a charge of public drunkenness is paradoxical, if the alcohol was consumed voluntarily. This plea would have little hope of success, even though it might be manifest that the accused could not have formed an intent to display his condition in public.

Does act presuppose intention?

Mens rea is a slippery phrase, even in the hands of the experts. The attitude of the courts to this defence in, say, drunk-driving cases, may not be relevant to the same defence if raised in a prosecution for public drunkenness. In the alcohol-related offences, such as drunk or impaired driving, the defence attempts to prove that the accused was so drunk as to be incapable of intending to drive, that is, of intending to do the very act charged. The courts get around this by saying that if he did the act, he must be assumed to have intended it.

But the defence to a charge of public drunkenness might be that the accused had no control over whether he became publicly intoxicated or not; he could not do anything to prevent it; whatever his intentions, he was powerless to resist; his action

was just as involuntary as if someone had held his arms and forced the gin down his throat. This is the argument that prevailed in *Easter*. Acceptance of the idea that the alcoholic's act in drinking is involuntary was essential to the decisions in both *Easter* and *Driver*.

"Perhaps a rope will help."

There is no certainty, even if this idea were accepted, that the defence would prevail in our courts. There is no constitutional guarantee against "cruel and unusual punishment," in provincial laws at least, to act as a spur. There is nothing in some statutes to suggest that the offence is not complete when the act occurs, regardless of its cause. Furthermore, this defence embodies a concept that is not only new, but points in a disturbing direction. If the alcoholic's consumption is involuntary and he should be excused from the consequences of public drunkenness for that reason, why should he be held responsible for any other conduct? What if he commits murder? Is this not also involuntary and, if involuntary, excusable? What if he drives his car and hurts someone? Is he not to be held guilty of dangerous driving, or of manslaughter? The defence of "compulsion" or "irresistible impulse" has had short shrift in Canadian courts. As one of our judges said in a case in 1908:

"The law says to men who say they are afflicted with irresistible impulses: if you cannot resist an impulse any other way, we will hang a rope in front of your eyes, and perhaps that will help."⁴

Perhaps from the point of view of humane treatment of the alcoholic, involuntary act *should* be a defence, but that is no guarantee that it will be accepted as one.

Thus alteration of the laws by court action alone appears to be an uncertain prospect. The only sure route is direct amendment of the statutes themselves. Some tentative steps have been taken in this direction. For instance, Part II of the Narcotic Control Act⁵ recognizes the status of "narcotic addict"

and provides for treatment instead of mere punishment. Section 17(1) reads:

Where a person who has been remanded to custody for observation and examination pursuant to section 16⁶ is convicted of the offence in respect of which he was remanded to such custody, the court shall, before passing sentence, consider the evidence arising out of the observation and examination, including the evidence of at least one duly qualified medical practitioner and such other evidence as may be adduced, and where the court is satisfied, upon consideration of such evidence, that the convicted person is a narcotic addict, the court shall, notwithstanding anything in section 15,⁷ sentence him to custody for treatment for an indeterminate period, in lieu of any other sentence that might be imposed for the offence of which he was convicted.

Lack of confidence in its effectiveness has prevented Part II from being brought into force and it remains, at least for the present, a dead letter.

The impulse for change is seen in the 1962 amendment to the Ontario Liquor Control Act.⁸ Section 80(2) provides that "No person shall be in an intoxicated condition in a public place." To the fines and jail sentences traditionally imposed was added authority for the magistrate in the following terms:

Where it appears that [a person who contravenes section 80(2)] may benefit therefrom, he may be ordered to be detained for a term of ninety days in an institution for the reclamation of alcoholics that is designated for the purpose by the Lieutenant Governor in Council, but, if at any time during his term the superintendent of the institution is of the opinion that further detention therein will not benefit him, the superintendent may release him.—Section 106(7) (c).

Only one such institution has been established in Ontario (the Alex. G. Brown Memorial Clinic in the Mimico Reformatory) and the amendment has thus had little effect. Again, lack of confidence in the measure appears to be inhibiting its development.

These cautious attempts might yet prove to be in the right

direction. The future requires two kinds of laws; one to control addiction and the other to control certain kinds of offensive or dangerous social behaviour, such as drug trafficking, drunk and disorderly behaviour and public drunkenness *per se*. Further tinkering with present laws would not seem to be the answer, because what is required is contradictory to what is presently provided.

We need new legislation based on the concept that addiction is a condition that requires treatment, not the result of moral lapse that requires punishment.

But what should the new laws say?

This conclusion — that we need new laws — is easy to achieve. It is more difficult to agree on what the new laws should say. It is agreed that addicts should be removed from the trappings of the criminal process. It is said that coercion should be avoided, for coercion is antithetical to treatment. Public drunks should be taken, not to jail, but to detoxication centres for examination and drying out, and to hospitals for treatment. Who is to take them — the police? Is this not retaining the appearance of the punitive process? What of those who refuse to go or, once there, refuse to stay? How can they be kept in such institutions without making these institutions into jails? And if addicts are to be kept, in their own interests but against their will, even for short periods, how can the need for a court order be avoided? If a court order is necessary, how can a true hearing process be avoided, with the addict given the right to a full hearing and defence? Once this point is conceded we have, willy-nilly, reached the position of holding a trial on a question of status — the status of being an addict.⁹

What is the point of such a trial? It has no point save to impose treatment upon an addict against his will. But, if coercion is at odds with effective treatment, what is the point of the entire process?

Perhaps the answer is to recognize the status of being an addict for the purpose of offering treatment. The addict could

accept or reject the treatment. If he is involved in a charge of, say, public intoxication, he may choose jail instead of a course of treatment. This is the proposal of the "you can lead a horse to water" school of thought. Having offered the choice, are we not justified in washing our hands of those who are so foolish as to refuse treatment? Those who cause problems of public order as a result should be in jail.

This approach appeals to the "practical" man. The trouble with it is that it might be ineffective. We are told that alcoholics are resistant to the idea that they are alcoholics or that they require treatment. If treatment is less congenial than jail, they are not likely to opt for treatment. Moreover it might be said that such alternatives are already available, at least in Ontario, where treatment centres throughout the province are ready to assist the volunteer. Yet the parade of skid-row drunks continues through the courts. Thus the proposal might not be as practical as it sounds.

What of the "home-bound" or private alcoholic? Present measures are ineffective. As an "habitué," who is incapable of managing his affairs or constitutes a danger to himself or his family, or as a mental incompetent, he can be placed in a mental hospital; but there is little belief that this measure has any rehabilitative value — its chief purpose appears to be the safe custody of hopeless cases.

What about civil liberties?

Unless a man is in such a condition, has society any right to reach into his home? And assuming that it has, how can this be done without coercion and the real possibility of an infringement of civil liberties? Must he not be left alone, so long as his conduct is not dangerous to others, and wooed into treatment? Again the trouble here is the reluctance of the alcoholic to acknowledge his condition and to seek treatment. Left to himself, he might do nothing. Society has an interest in helping him despite himself; for even his example, without

any dangerous behaviour, might encourage others to go the same route.

These are merely some of the questions that arise. They will not be answered overnight. But answers must be found, and found soon; for the rising spectre of addiction, to alcohol, drugs, barbiturates, tranquillizers and stimulants—even to tobacco—is an ominous and growing threat to the management and the enjoyment of the world we live in.

Notes

¹*Driver v. Hinnant*, 243 F. Supp. 95 (E.D.N.C. 1965), *rev'd*, 356 F. 2d 761 (4th Cir. 1966). "The United States Court of Appeals for the Fourth Circuit—which includes the States of Maryland, Virginia, West Virginia, North Carolina and South Carolina—held that to convict a chronic alcoholic for public intoxication and thus to ignore the common law principle followed in the *Easter* case [see note 2 below], violates the prohibition against cruel and unusual punishment contained in the Eighth Amendment to the United States Constitution."—Peter Barton Hutt, "The Recent Court Decisions on Alcoholism," a paper presented at the seventeenth annual meeting of the North American Association of Alcoholism Programs at Albuquerque, New Mexico, in October, 1966. Mr. Hutt appeared for *amici curiae* in the *Driver* case and represented appellant DeWitt Easter in the *Easter* case (see note 2).

The Eighth Amendment referred to, one of the first ten amendments to the U.S. Constitution which collectively are known as the Bill of Rights, reads: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

²*Easter v. District of Columbia*, 209 A. 2d 625 (D.C. Ct. App. 1965), *rev'd. en banc*,—F. 2d—(D.C. Circuit No. 19365, March 31, 1966). "The United States Court of Appeals for the District of Columbia Circuit held that the well-settled common law principle, that conduct cannot be criminal unless it is *voluntary*, precludes the conviction of a chronic alcoholic for public intoxication."—Hutt, *op. cit.* The paper is No. 31 of the Special Report Series published by the NAAAP (323 Dupont Circle Bldg., Washington, D.C. 20036).

See also Hutt and Richard A. Merrill, "Is The Alcoholic Immune From Criminal Prosecution?" in the July, 1966, issue of *The Municipal Court Review* (1480 Hoyt Street, Denver, Colorado 80215). Mr.

Merrill was associated with Mr. Hutt in the *Easter* appeal.

Further discussion on the *Driver* and *Easter* decisions may be found in the July-September, 1966, issue of *Inventory*, a quarterly journal on alcohol and alcoholism published by the North Carolina Alcoholic Rehabilitation Program (P.O. Box 9494, Raleigh, N.C. 27603). This issue contains a talk by Mr. Hutt at the annual conference of the (U.S.) National Council on Alcoholism in March, 1966, and some comments by Judge John M. Murtagh, Administrative Judge of the Criminal Court of the City of New York. (An article by Judge Murtagh, "Dilemma for Drug Addicts—U.S. Version," appeared in the Winter, 1965, issue of ADDICTIONS.)

³S.C. 1960, 8-9 Eliz. II, c.44, s.2(b).

⁴Riddell J. in *Rex v. Creighton* (1908), 14 C.C.C. 349.

⁵S.C. 1961, 9-10 Eliz. II, c.35, as amended.

⁶Section 16 reads: "Where any person is charged with an offence under section 3, 4 or 5 [these sections deal, respectively, with possession, trafficking and importing], the court or any judge having jurisdiction to try the offence may, upon application by counsel for the Crown, or upon application by the person charged with the offence or by counsel for such person, either before or after such person is committed for trial and before any sentence that might be imposed for the offence is passed, remand such person, by order in writing, to such custody as the court directs for observation and examination for a period not exceeding seven days."

⁷Section 15 reads: "Where a person is convicted of an offence under section 4 or 5, the court shall, if that person (a) has been previously convicted on at least one separate and independent occasion of an offence under section 4 or 5 of this Act, . . . or (b) has been previously sentenced to preventive detention under this section, impose a sentence of preventive detention in a penitentiary for an indeterminate period, in lieu of any other sentence that might be imposed for the offence of which he was convicted."

⁸R.S.O. 1960, c. 217, as amended.

⁹For a recent U.S. decision affecting a trial on a question of status, see *Robinson v. California*, 370 U.S. 660 (1962). "*Robinson v. California* is a landmark constitutional law decision because, for the first time, the prohibition of the Eighth Amendment against cruel and unusual punishment has been utilized by the Supreme Court (via the Fourteenth

Amendment) to nullify the substantive provisions of a state criminal code as distinguished from the penalties imposed by the code. *Robinson* held that the 'status' or 'condition' of involuntary narcotic addiction could not be either criminally classified or criminally punished by the State of California."—Samuel M. Kirbens, "Not Guilty By Reason Of Chronic Alcoholism," *The Municipal Court Review*, July, 1966. In this article, Judge Kirbens discusses the legal and practical implications of what he describes as "the judicial triple-play of *Robinson* to *Driver* to *Easter*."

The relevant portion of the Fourteenth Amendment to which Judge Kirbens refers is Section 1, which reads: "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

Don't Blame the Policeman

by Kenneth M. Green, M.Sc.

In our society the most common treatment for alcoholism is probably punishment in the form of a fine or imprisonment. Many people, aware of the prevalence of this futile practice, direct a lot of strong criticism towards the police for initiating this procedure. A closer look will reveal that this criticism is quite unfair.

In years gone by, handling a chronic drunk was probably less of a problem for the police officer than it is today—not because yesterday's drunks were any fewer or any less troublesome to load in the paddy wagon, but simply because the police officer's task was more straightforward. If a little rough handling was required to subdue and lock up an offender, the public generally accepted it as probably no more than what the drunk deserved

Mr. Green is Assistant Regional Director (Community Programs) for the Lake Erie Region of this Foundation. He has lectured from time to time on police handling of alcoholic offenders, both at the Ontario Police College at Aylmer, and to the London City Police.

for his "despicable" behaviour. But now that we have become "enlightened," the problem is more involved. We now know that many chronically drunken persons are alcoholics and that, for these, punishment is neither a just nor an effective solution.

However, it is not always easy to tell at a glance the person who is merely an irresponsible excessive drinker from the true alcoholic. Judging from his behaviour and by all appearances the alcoholic, too, acts quite irresponsibly. When intoxicated, he walks or drives in great peril, he often needs help to get home or to avoid injury, he may be ill, insulting, or violent—in short, the alcoholic often resembles the ordinary Saturday-night hell-raiser. Nor does the alcoholic himself give much help to those who try to distinguish him from the ordinary drunk. His disorder is characterized by loud and offensive denial, and he becomes completely overwhelming—if not entirely convincing—in his proclamation of his normality. Almost automatically, such a person provokes the kind of hostility that longs to express itself by means of a well-placed kick.

But let us suppose the real alcoholic *could* be identified by some quick, easy method, and that the police officer's attitude, consequently, becomes tolerant and sympathetic. This is precisely where the policeman's real dilemma begins. Increasingly, policemen are taking their training and responsibility seriously. They want to separate the "bad" guys from the "sick" guys, because they know that each requires different handling and processing. The "bad" guys are a cinch, but they are at a loss to know what should be done with the ones that need help.

Where's the humanitarian?

If officers become cynical at this point, it is with ample justification. Social scientists have chronically assailed law-enforcement officers for being brutal and punitive to people who really need human understanding and treatment. But when an officer has a back seat full of kicking, swearing "humanity in need of help," where does he find a humanitarian? The embarrassing answer is, of course, that no one wants to provide the

help. This lack of support exists for other disturbances as well as alcoholism. Police have been known to rush the same man to hospital three times in the same evening to have a lethal dose of pills pumped out of his stomach, and each time they have been appalled to see the man returned to the street instead of being admitted.

Where do we take the drunk?

But the quandary about where to take the inebriate, if he is not to be taken to jail, is a much larger one. Almost universally, among agencies set up to help with human problems, there is a denial of responsibility for this particular problem. The church, which frequently regards alcoholism as a moral problem, generally seeks to eliminate it through legal and social controls. Social workers, normally concerned about social problems, are happy to agree that alcoholism is a disease—and that it should be treated by a doctor. The doctor is generally too busy to give it much attention, and if the alcoholic takes the drugs the doctor prescribed and washes them down with a bottle of wine, the doctor is sure the man should see a psychiatrist. And although psychiatrists are generally considered the most skilful practitioners for the more perplexing human problems, many are inclined either to proclaim that alcoholics are hopeless, or, alternatively, to profess that alcoholics can be more effectively treated by non-professional lay people: for example, Alcoholics Anonymous.

While the police find very little co-operation from the professional community in handling the pathological drinker, they often find that even the simple process of arrest is complicated by a community that can't make up its mind. Businessmen frequently insist on a clean-up of drunks, but when an officer arrives on the scene of an incident he may have to battle both the hostile drunk and an indignant street crowd that is ready to defend the offender.

So don't blame the police officer if he is fed up with the whole mess.

Legislators' Views on Alcoholism

— a California study

by Richard H. Blum, Ph.D., and Mary Lou Funkhouser, A.B.

Fifty of the fifty-two California legislators holding key positions on committees which process drug bills were interviewed. Information on a number of problems and issues was elicited for testing several hypotheses relating the positions of the legislators on drugs to their political stand and their willingness to go against perceived public opinion. A major focus was on the acceptance or rejection of behavioural scientists, including psychiatrists, as expert information sources for drug legislation. Most of the legislators were found to take a dim view of what these scientists currently have to offer the legislative process. Also, in a test of a hypothesis, legislators who were rated philosophically as pragmatists were found to be more accepting of behavioural science and scientists than those rated as moral absolutists. The full study has been reported elsewhere.¹

Alcohol and other drugs

Several of our inquiries were directed toward the positions of legislators on alcohol in contrast with other drugs affecting the mind. Legislators clearly distinguish between alcohol and other dependence-producing drugs. The latter, ranging from heroin to marihuana, tend to be grouped together. For example, when discussing either narcotic or dangerous drugs, legislators emphasize such aims as control of distribution, deterring further offences through penalties, and stigmatizing drug-taking by pronouncing it criminal. The average legislator believes that the public demands a punitive approach to users of narcotic or

Dr. Blum is Director of the Pharmacology Project at the Institute for the Study of Human Problems at Stanford; he is also a lecturer at the Center for Training in Community Psychiatry at Berkeley, Consulting Criminologist for the San Mateo County Sheriff's Department and Consultant to the President's Crime Commission. Miss Funkhouser (now Mrs. Balbaky) is a research assistant at the Institute. This paper is reprinted by permission from the *Quarterly Journal of Studies on Alcohol*, Vol. 26, pp. 666-669, 1965. (Copyright, 1965, by Journal of Studies on Alcohol, Inc., New Brunswick, N.J., U.S.A.)

dangerous drugs; often they contrast their own position with that of their constituents, for they see themselves (Democrats especially) as considerably more rehabilitation-oriented and "liberal" than the punishment-control-oriented public.

Alcohol considered different

Alcohol is not considered in the same way, nor do legislators believe the public to regard its use with the same emotions or demands for protection as surround views of non-alcoholic "drug addicts." For the most part legislators appear to have a greater flexibility in their approach to alcoholism; they appear willing to entertain a variety of constructive proposals for dealing with the alcoholic. As a corollary, the average legislator describes the public as disinterested in alcoholism, as not concerned with alcohol abuse as a social problem, or as being sympathetic with the alcoholic. The sense of fearful menace or outrage which some see in public responses to narcotic and dangerous drug use is not reported for alcoholism. It is not surprising that under these circumstances some legislators believe that the public is ready to accept treatment rather than criminal prosecution for the public inebriate.

During the course of the interview each legislator was presented with three hypothetical legislative proposals. One hypothetical bill would make the hallucinogenic drug lysergide (LSD-25) available by classifying it as a dangerous drug, which would enable physicians to prescribe it. A second bill would make the use of marihuana legal, subject only to the same controls that now govern alcohol sales. The third bill would remove public inebriates from the concern of the criminal law and transfer their handling to public-health and medical authorities. As proposed, that bill would limit police intervention to 24-hour protective custody prior to mandatory medical disposition.

For each bill the legislators were asked what information they would need to decide their own position, whom they would

rely on to provide the information, and how they would vote if the bill were up for immediate decision.

On the lysergide bill, more than half felt they needed more information, mostly about the potential dangers and benefits of the drug. To get information, these lawmakers would rely most heavily on physicians, especially representatives of organized medicine; somewhat less often, they would rely on law-enforcement agencies for their data. Few would turn to behavioural scientists, psychiatrists, or university medical people. If a vote were taken today at least one-third would reject any liberalization of access to lysergide.*

Would keep marihuana banned

On the marihuana-legalizing bill, half knew everything they wanted to know: the drug is bad and should be outlawed. Less adamant legislators would also vote against it because of the widespread public sentiment against marihuana. Only a few legislators were willing to consider voting for it, and they would require information proving its benefits, proving public acceptance, and proving the absence of any step between marihuana and progression to the use of addicting drugs. Again, behavioural scientists and medical scholars were rarely considered as information sources.

In comparison to lysergide and marihuana, there was much greater willingness among the lawmakers to consider a change in present practice on public inebriety and to be interested in new proposals and new information. In keeping with that

*During the Spring of 1966 a strenuous debate took place before and within the committees of the California Legislature over the proposal that LSD be defined as a "dangerous drug" for use in research only and that its possession (without valid prescription) become a felony. Felony possession was twice defeated in committee but, in a flurry of political activity involving law-enforcement witnesses and threatening to involve top politicians, it was reported out and passed into law. Now under the law an addict (person with prior record of drug offences) may receive up to one year in jail on a first offence for LSD possession (without intent to sell); non-addicts on a first offence can receive a maximum of six months in jail. For a second offence the maximum penalty increases to up to five years in prison. Probation remains the minimum sentence. The felony possession feature of the bill can be considered a victory of the "get tough with addicts" advocates over the "soft-line" advocates of medical-social handling for identified drug-dependent persons.—R. H. B., August, 1966.

genuine interest, the lawmakers were much more specific about the kinds of data they wanted concerning any proposed new program. Desired would be information on the mechanics of a new program (facilities, processes, etc.), costs and sources of funds, proof of benefits, much more detailed information about alcoholics themselves and how they would respond, and, finally, data from other states or nations showing how new programs had worked. Underlying some of the remarks was a concern that the "drunks" handled under a non-punitive program should still be responsible under penal statutes for any criminal offences committed while under the influence of alcohol.

Even split on drunk bill

In a vote today, legislators would split rather evenly: one-third would oppose it, one-third would vote for it providing it could be administered without increased taxes, and one-third were uncertain. The latter group especially needed reassurance that alcoholics would not take advantage of the removal of penalties to abandon all interest in giving up their drinking excesses.

The problem of pressure groups was raised in discussing alcohol legislation. The legislators said that opposition to non-punitive handling of alcoholics would come from police and district attorneys because these people lacked faith in rehabilitation. Church and temperance people would also oppose any bill which would remove stigma from drinking, for, the lawmakers believe, temperance folk hold that drinking is evil and must be denounced through arrest and conviction. If medical treatment implies acceptance of alcoholism as a disease without moral implications, that would be seen to encourage drinking. Also mentioned as a pressure group was the liquor industry, which opposes any bill that includes costs they must pay, or threatens sales in any way. Taxpayers' organizations and civic groups would also oppose any bill which appeared to "menace" the community—either its tax rate or the safety of its citizens. Civil-liberties spokesmen, termed "extremists" by some law-

makers, would also be concerned with any bill that institutionalized addicts against their will in a medical facility or stigmatized them as "alcoholics" without due process of law.

The presence of so much opposition to "liberalized" laws about alcoholics would not necessarily influence legislators. They are used to lobbyists and do not appear to fear them. As long as pressure groups exist on both sides of a question, the consensus of the legislators seemed to be that they would abide by what they conceived to be the wishes of their constituents plus their own evaluation of what was necessary and proper.

It is worth noting that the bill "liberalizing" the handling of alcoholics by emphasizing non-punitive approaches can evoke opposition from political "liberals" as well as conservatives. The latter fear that the reduced emphasis on personal responsibility for conduct will lessen the alcoholic's motivation to overcome his "weakness," and further, that shifting the social-control emphasis from police to health personnel may threaten community safety in general. The liberals, on the other hand, fear that medical handling jeopardizes the civil liberties of the alcoholic whereas present judicial procedures do not. "Welfare bills may actually take people's rights away from them. It's better to be arrested as a drunk than [confined] as an alcoholic."

Reported unhappy experiences

The legislators were asked to discuss their own personal experiences with persons who had abused drugs. Half of those willing to do so did report unhappy experiences, mostly with relatives, clients or employees who had been alcoholics. Only a few indicated that their own experiences had coloured their subsequent thinking; and legislators with similar unhappy experiences came to quite different conclusions about what must be done. Several claimed to have realized that alcoholism was a disease; one gave up drinking; another said it was a psychological and social problem; another concluded that the alcoholic might not be responsible for what he did after all, but that the control-penalty approach must be continued because (a) one would

not want to "dignify self-induced drunkenness" and, (b) regardless of the plight of the individual, punitive legislation best protects the welfare of the society—by stigmatizing and deterring drunkenness.

Tentative conclusions

On the basis of our interviews and our prior work on attitudes toward the use of drugs,² we offer the following tentative conclusions.

1. In California, at least, legislators are willing to consider new approaches to handling alcoholics, provided new proposals can demonstrate the feasibility of administrative apparatus and involve no increase in taxes, and provided the criticism of anti-rehabilitation lobbies can be countered by argument and demonstrations of interest on the part of important citizens' groups favouring the new legislation.

2. In terms of legislative change, legislators make a strong distinction between alcohol and other dependence-producing drugs. Changes in current approaches to alcoholism will be considered, but the predominant control-punishment and incarceration-and-treatment approach to narcotic and dangerous-drug offenders seems much more strongly rooted.

3. Those who primarily advocate control and punishment and those who fear the consequences of non-punitive approaches to drug abuse tend to be conservative on matters unrelated to drug legislation. Most often they are Republicans and, when rated on philosophical position, emerge as moral absolutists rather than pragmatists. The philosophical dimension is, in turn, associated with readiness to accept or reject the opinions of behavioural scientists and psychiatrists testifying on drug legislation.

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The Alcoholism and Drug Addiction Research Foundation was established in 1949 by an act of the Ontario Legislature and is financed mainly by an annual government grant. Its objects are:

- to conduct and promote research in alcoholism and other forms of addiction; and
- to conduct, direct and promote programs for:
 - the treatment and rehabilitation of alcoholics and other addicts,
 - experimentation in methods of treating and rehabilitating alcoholics and other addicts, and
 - the dissemination of information respecting the recognition, prevention and treatment of alcoholism and other forms of addiction.

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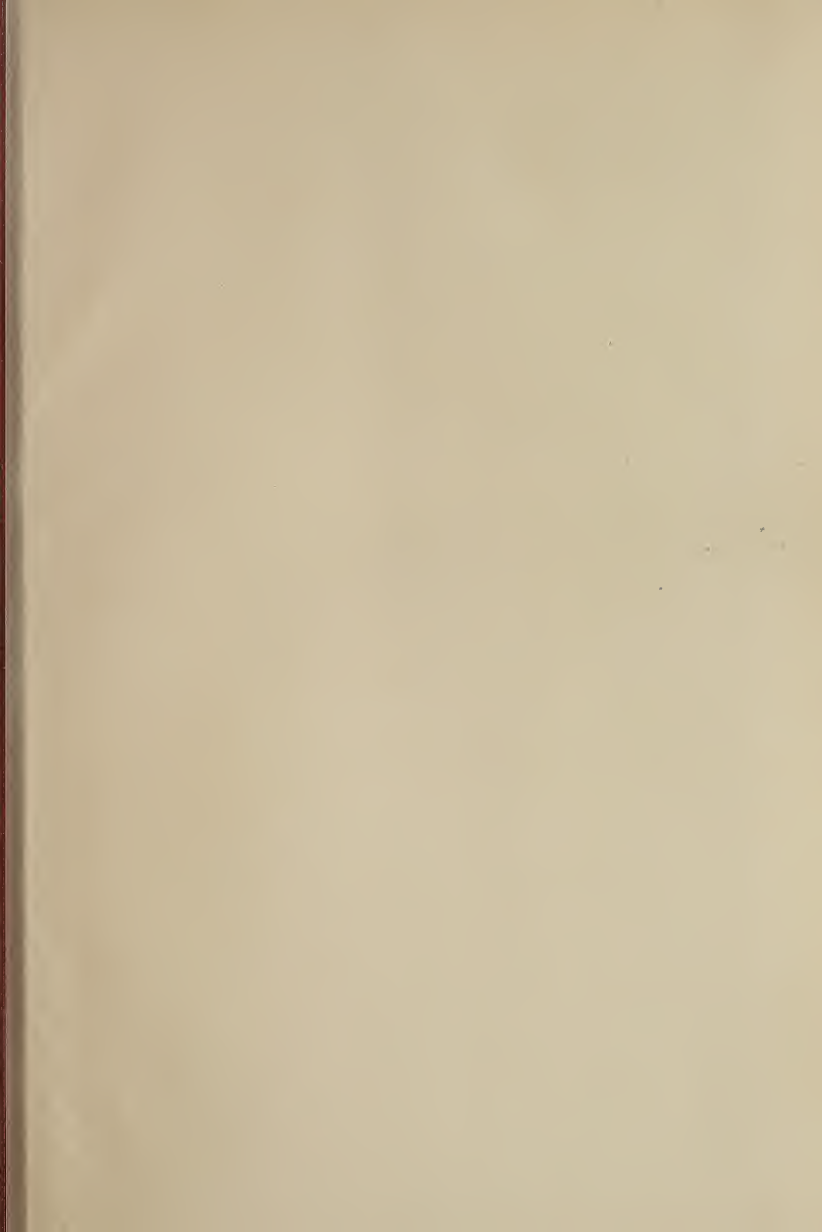
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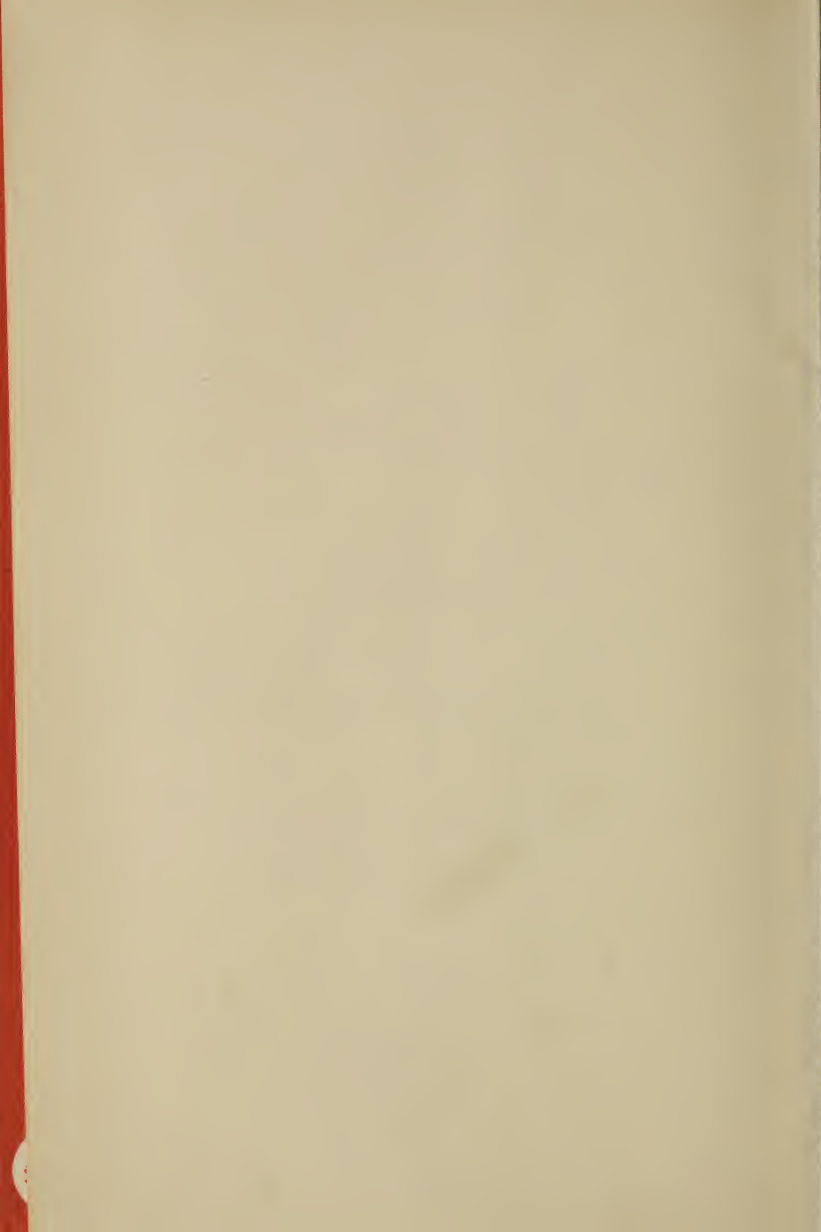
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